

---

Citation:

Utoblo, B (2017) MEN'S RECOVERY FROM SCHIZOPHRENIA IN NORTHERN NIGERIA. Doctoral thesis, Leeds Beckett University.

Link to Leeds Beckett Repository record:

<https://eprints.leedsbeckett.ac.uk/id/eprint/4997/>

Document Version:

Thesis (Published Version)

---

The aim of the Leeds Beckett Repository is to provide open access to our research, as required by funder policies and permitted by publishers and copyright law.

The Leeds Beckett repository holds a wide range of publications, each of which has been checked for copyright and the relevant embargo period has been applied by the Research Services team.

We operate on a standard take-down policy. If you are the author or publisher of an output and you would like it removed from the repository, please [contact us](#) and we will investigate on a case-by-case basis.

Each thesis in the repository has been cleared where necessary by the author for third party copyright. If you would like a thesis to be removed from the repository or believe there is an issue with copyright, please contact us on [openaccess@leedsbeckett.ac.uk](mailto:openaccess@leedsbeckett.ac.uk) and we will investigate on a case-by-case basis.

# **MEN'S RECOVERY FROM SCHIZOPHRENIA IN NORTHERN NIGERIA**

BELLO UTOBLO

A thesis submitted in partial fulfillment of the requirements of Leeds Beckett University  
for the degree of Doctor of Philosophy

SEPTEMBER 2017

## Abstract

**Background:** Schizophrenia is a chronic and severe mental health difficulty that affects over twenty-one million people worldwide. In Nigeria, it is estimated that there are more men than women living with schizophrenia. Although, there have been studies on men and health in Nigeria, these have focused on sexual health or violence. In contrast, men's experience of schizophrenia, and the role of gender in influencing their beliefs about recovery has not been explored.

**Aim:** The aim of this qualitative study was to explore the factors influencing men's recovery from schizophrenia in northern Nigeria.

**Method:** Thirty male outpatients aged between 18 and 65 and ten mental health practitioners (psychiatrists and nurses) were purposively sampled and recruited through Nigerian psychiatric hospital outpatient clinics. Data were collected using individual interviews, and analysed through Braun and Clarke's (2006) analytical framework.

**Results:** The findings suggest that participants identified three themes on recovery from mental illness: western medicine, traditional medicine, and family support. Whilst, western medicine aided relief of symptoms associated with schizophrenia, costs and side effects of these medications hindered their utilisation. The participants' also highlight the significance of religion to recovery, premised on the belief that God is a healer, therefore the data suggests that many endowed the agency of their recovery to God. Alongside these, the role of family support was vital in facilitating participants' links to healthcare. Cross cutting these themes is the notion of gender flexibility. Traditional masculinity expectations of being the head of the household involves stressful challenges that can increase the threat of developing schizophrenia. In contrast, the presence of gender flexibility within household members, where their contributions changed over time, were seen as influencing the men's ability to become involved in recovery. In particular, providing for the family needs becomes a shared responsibility, where the departure from traditional gender imposes fewer family hardships, thus aiding the men's willingness to seek help, which rolls over to their recovery.

**Conclusion:** The influence of gender flexibility demonstrated in this study has implications for understanding the causes of schizophrenia and its recovery. This includes the need for gender educational awareness programmes for the men and those involved in their care. Future research is needed to explore in more detail how the conceptualisation of gender impacts on men's mental health within the Nigerian and wider African context.

## Acknowledgments

This thesis is dedicated to my family. I am enormously grateful for their endless patience and kindness during the progression of my PhD study. Sadly, during the period of my fieldwork in Nigeria, there was a family bereavement. My family lost our mother Mrs Otali Beatrice Utoblo. It was a very difficult time for the family, and my family is still struggling with the loss.

There are many people who have contributed knowledge and time to this project. However, I would like to thank Leeds Beckett University for the educational platform for this study especially I would like to thank the University Research Office (Joanne Burgess) for the help and support. Special thanks to Professor Alan White and Professor Steve Robertson, my supervisors, for their guidance and support in the progression and construction of this thesis. In particular, Alan is the Director of my PhD study. This study would not have been possible if it were not for Alan and Steve's theoretical guidance on masculinities and wider concepts. This has transformed my perspectives on gender and encouraged me to think how theory would be translated into practice in Nigeria and the wider African context.

I would also like to thank some of my Nigerian friends who have often assisted with material and financial support. In particular, Tahir Yusuf. The implementation of this study in Nigeria, would have been difficult without material and financial support from Yusuf and Tad Balogun. I also thank Professor J Isawa Elaigwu. Desmond Jumbo in Nigeria, supported me with picking me up from the airport and the place where I stayed in Abuja.

Last, but certainly not least, this project would not have happened without the support of the Federal Neuropsychiatric Hospital in northern Nigeria. I would like to sincerely thank the Medical Director of the psychiatric hospital, who believed in the project from the beginning. I would also like to thank all the participants in this study who agreed to take part and gave up their time to be interviewed. Without them this thesis would not have been possible. Their discussions have been very valuable and I have learnt so much from their knowledge and their insights. To maintain their anonymity, I do not name them but am grateful for their input and time to take part in the study.

I sincerely thank Dr Liz Cashdan for her help in correcting my English language expression and Dr Loretta Ogboro-Okor for our library discussion. Dr Louis Gyoh and Ene Ojoma Odeh always encouraged me and I am grateful for this support. All these people have provided me with the opportunity to reflect on my work, the confidence to express my views and enthusiasm in the face of adversity. And to all of them I say thank you.

## Contents

Abstract.....	i
Acknowledgments.....	ii
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introduction .....	1
1.2 Background to this qualitative study .....	1
1.3 Aim of the research.....	6
1.4 Research questions .....	6
1.5 Objectives of the research .....	6
1.6 Structure of the thesis.....	8
CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL DISCUSSION ON GENDER.....	11
2.1 Introduction.....	11
2.2 Meanings of gender.....	11
2.3 Concepts of masculine expectations .....	12
2.3.1 Men in the family .....	13
2.3.2 Marriage and fatherhood .....	15
2.3.3 Men as worker .....	17
2.4 Changing men's identity in modern Africa .....	18
2.4.1 Post-colonial development in Nigeria.....	19
2.4.2 Impact of Structural Adjustment Programme (SAP) .....	27
2.4.3 Introduction of gender policies.....	29
2.5 Gender and men's health .....	30
2.5.1 Hegemonic masculinity and men's health risks.....	30
2.5.2 Traditional African masculinity as a social issue .....	34
2.5.3 Gender flexibility and men's mental health.....	37
2.6 Summary .....	45
CHAPTER THREE: LITERATURE REVIEW AND CONCEPTUAL DISCUSSION ON SCHIZOPHRENIA AND RECOVERY .....	46
3.1 Introduction .....	46
3.2 Diagnosis of schizophrenia.....	46
3.3 Burden of schizophrenia .....	50
3.4 Conceptualisation of the causes of schizophrenia.....	51
3.4.1 Biological approach.....	51
3.4.2 Anti-psychiatry .....	54

3.4.3 Psychosocial model .....	59
3.4.4 Religious-spiritual beliefs .....	62
3.5 Definitions of recovery .....	65
3.6 Approaches to recovery from schizophrenia .....	69
3.6.1 Western biomedical model .....	69
3.6.2 Religion and spirituality .....	72
3.6.3 Influence of family support .....	84
3.7 Summary .....	89
CHAPTER FOUR: METHODOLOGY AND METHODS FOR RESEARCHING NIGERIAN PATIENTS RECOVERY FROM SCHIZOPHRENIA .....	90
4.1 Introduction .....	90
4.2 Methodology .....	90
4.3 Methods .....	94
4.3.1 Purposive sampling .....	95
4.3.2 Overview of study sample .....	96
4.3.3 Recruitment of participants .....	99
4.3.4 Data collection .....	101
4.3.5 Data analysis .....	107
4.3.6 Demonstrating rigour .....	113
4.3.7 Ethical considerations in health research .....	116
4.4 Reflexivity in health research with Nigerian patients .....	120
4.5 Summary .....	123
CHAPTER FIVE .....	125
“As a man, I am supposed to be the head of my family, so I have to provide for my wife and children, even though this put pressure on me to do as expected of a man”: UNDERSTANDING GENDER EXPECTATIONS AND THEIR IMPACT .....	125
5.1 Introduction .....	125
5.2 Definitions of gender .....	125
5.2.1 Gender as traditionally fixed .....	127
5.2.2 Non-traditional gender flexibility .....	130
5.3 Male head of the household model and links to schizophrenia .....	133
5.3.1 Marriage expectations .....	133
5.3.2 Man as worker .....	140
5.4 Influence of gender on help-seeking .....	145
5.5 Summary .....	147

CHAPTER SIX.....	148
“It is the will of God and evil spirits, but sometimes you can get it through hereditary”: RELIGIOUS- SPIRITUAL BELIEFS AND BIOLOGICAL CAUSES OF SCHIZOPHRENIA. ....	148
6.1 Introduction .....	148
6.2 Symptoms of schizophrenia.....	148
6.3 Schizophrenia as a religious-spiritual phenomenon.....	156
6.3.1 God’s will.....	156
6.3.2 Ancestral spirits.....	159
6.3.3 Jinn possession.....	163
6.4 Biological causes of schizophrenia.....	165
6.5 Summary .....	169
CHAPTER SEVEN.....	170
“It is not only one thing that can make you get better from this kind of mental illness. I think there are different things which all can help in different ways to help you get better”: EXPLORING RECOVERY AS MULTIFACTORIAL.....	170
7.1 Introduction .....	170
7.2 Definitions of recovery.....	170
7.2.1 Recovery as getting better.....	170
7.2.2 Symptoms relief as feature of recovery.....	172
7.2.3 Expected roles return in recovery.....	176
7.3 Factors influencing men’s recovery from schizophrenia .....	179
7.3.1 Western medicine .....	179
7.3.2 Religion and traditional sources .....	193
7.3.3 Family influence .....	206
7.3.4 Influence of gender flexibility .....	216
7.4 Summary .....	217
CHAPTER EIGHT: DISCUSSION OF FINDINGS.....	218
8.1 Introduction .....	218
8.2 Changing beliefs: western medicine, religion and causation of schizophrenia .....	218
8.3 Role of gender flexibility in men’s recovery .....	227
8.4 Views about recovery from schizophrenia .....	232
8.5 Limitations of the study .....	247
8.6 Summary .....	250
CHAPTER NINE: SUMMARY OF FINDINGS AND CONCLUSION .....	253
9.1 Introduction .....	253

9.2 Triggers exacerbating schizophrenia .....	253
9.3 Turning points to recovery.....	255
9.4 Study implications.....	256
9.4.1 Implications of findings for healthcare practice .....	256
9.4.2 Implications of this study for health policy.....	257
9.4.3 Implications of the study for future research.....	258
9.5 Conclusion.....	259
REFERENCES.....	260
APPENDIX ONE RESEARCH PROTOCOL .....	292
APPENDIX TWO A MAP OF NIGERIA .....	294
APPENDIX THREE: INVITATION LETTER TO STUDY PARTICIPANTS.....	296
APPENDIX FOUR: PARTICIPANT INFORMATION SHEET .....	297
APPENDIX FIVE: PARTICIPANT REPLY SLIP .....	301
APPENDIX SIX: THE CONSENT FORM .....	302
APPENDIX SEVEN: INTERVIEW GUIDE.....	303
APPENDIX EIGHT: UNIVERSITY ETHICAL APPROVAL 2012 .....	307
APPENDIX NINE: ETHICAL APPROVAL STAFF INCLUSION 2013.....	309
APPENDIX TEN: HOSPITAL ETHICAL APPROVAL 2012 .....	311
APPENDIX ELEVEN HOSPITAL ETHICAL APPROVAL 2013 .....	312



# CHAPTER ONE: INTRODUCTION

## 1.1 Introduction

In this chapter, I provide the justification for conducting this study. I begin by providing a definition of schizophrenia and some data about its incidence. In furthering discussion about the nature of schizophrenia, I highlight the impact of mental health difficulties on the individual and the burden of care among families of service users' with mental health problem. I then introduce the current research gaps in relation to the people who use services' perceptions and experiences of schizophrenia and the role of gender within this. In the last part of this chapter, the organisation and structure of the thesis is outlined.

## 1.2 Background to this qualitative study

The Diagnostic and Statistical Manual of Mental Disorders-DSM 5 (American Psychiatric Association, 2013) and the International Classification of Diseases (World Health Organisation, 2010), the main guides used by health professionals to aid diagnosis of schizophrenia, highlight schizophrenia as a severe mental health problem, characterised by symptoms and changes in the behaviour of the individual. In one study of 1,080 patients, Bauer et al. (2011) suggests that people with schizophrenia can exhibit symptoms such as hearing or seeing things that are not there (hallucinations) or have false beliefs (delusions) that are outside of reality and not experienced by others. Morrison (2014) also associated wandering or roaming the streets and sleeplessness with onset of the condition.

Concerns about schizophrenia as a global health challenge have been raised by the World Health Organisation (2015a) where the condition is highlighted as a severe mental health problem affecting more than twenty-one million people worldwide. It is reported to be more common in men, with around 12 million males affected as compared to 9 million females (World Health Organisation, 2015a).

Studies of schizophrenia in Africa also reflect the higher incidence in males. A study by Kebede, et al. (2003) completed a survey in Ethiopia, to identify cases of schizophrenia and found that of the 321 cases of schizophrenia, 267 were males. Similarly, hospital admissions records were checked by Burns and Esterhuizen (2008) in a study of incidence of schizophrenia in KwaZulu-Natal, South Africa, where the data suggests that of the 160 cases of schizophrenia, 113 were male.

In Nigeria, inpatient admissions at a psychiatric hospital were conducted in a study by Ukpong and Mosaku (2009) where the hospital records of 584 patients admitted indicate that the incidence of schizophrenia is higher in men than in women. Data from their study suggests that the incidence of schizophrenia was 384 among males and 200 in females. In one such study, Afolayan, Peter and Amasueba, (2010) examined the prevalence of schizophrenia among service users admitted into the Neuropsychiatric Hospital, Port-Harcourt Nigeria, between 2005 and 2009. Their study suggests that the majority of the service users admitted between the study periods had a diagnosis of schizophrenia and that men were at a greater risk of developing the mental illness. Data in that study also showed that of the 4494 patients with diagnosis of schizophrenia admitted into the psychiatric hospital, 2653 were males and 1841 were females. In another study, Esan and Fawole (2013) investigated hospital records of

patients admitted to the Univeristy College Hospital, Ibadan, Nigeria where there was a male predominance in their sample with 125 males identified as having schizophrenia compared to 118 females.

There have been some concerns about the burden of schizophrenia to the individual with the condition. In particular, that people with schizophrenia are at high risk of harm to self and others have been raised in a study by Honings et al. (2015) where the mental health problem was associated with suicide. Among patients admitted to the Neuropsychiatric Hospital Abeokuta, Nigeria, those who manifested risk of self-harm and harm to others in the study by Amoo and Fatoye (2010) were reported to have schizophrenia. The associated symptoms of the condition, such as the presence of delusions and hallucinations were observed to be mainly responsible for this link to harm to self and others.

This view about the role of symptoms of schizophrenia was not limited to increasing risk of harm, however, as Ramsay, Stewart and Compton's (2012) study found among 181 patients in the United States of America that their symptoms had a disruptive impact influencing the majority of the participants' ability to carry on with day-to-day tasks, such as going to work. Consequently, a significant finding in that study is the remarkably high rate of unemployment in their sample of people with schizophrenia. Knapp, Mangalore and Simon (2004) provides evidence of the association between symptoms of schizophrenia and increased risk of unemployment suggesting that majority of people with schizophrenia in the United Kingdom, could be unemployed due to presence of symptoms associated with the condition.

In a qualitative study from Nigeria, Campbell et al. (2015 ) similarly provide insights into the difficulties which can be associated with schizophrenia. Their study among outpatients at the Lagos University Teaching Hospital, found a significant level of unemployment in the sample, mostly as result of the disruptions caused by the symptoms of schizophrenia. In the same vein, Adewuya and Makanjuola (2010) suggests that the majority of the 99 patients attending at the Obafemi Awolowo University Teaching Hospital in Ile-Ife, Nigeria were unemployed and the reason for this was related to the disruptive symptoms of their schizophrenia.

In addition to the impact on the individual of having symptoms associated with schizophrenia, there is a growing evidence showing that burden of care was a common problem for families of patients with the mental health condition. In a study exploring the experience of caring for relatives with mental health problem in the United Kingdom, Stansfeld et al. (2014) suggests that fulfilment of this role can have a stressful impact on a family member caring for a relative with the mental health difficulties, including interrupted or disturbances in sleep and debt problems.

A Ghanaian study by Ae-Ngibise, et al. (2015) found that whilst there is a culture of strong family support, where responsibilities around caregiving were mostly shared among close relatives, however, the burden of care was a common problem of relatives of patients with schizophrenia in their study. Carers' who assist their relatives reported various burden, which included financial responsibilities and lack of support networks. In Nigeria, research has also shown that many families of people with mental illness face numerous challenges. In a study assessing the impact of caring for a person with schizophrenia, Lasebikan and Ayinde (2013) observed that these responsibilities had financial implications for families of relatives with the

condition. In particular, deficiency in Nigerian healthcare provision, in relation to the service seen in western countries, (where treatment is administered through services that are free at point of use), means that families were required to pay for the healthcare costs of their relatives. Consequently, within this Nigerian system, almost the entire care burden falls to the family. However, the concern with this as Eaton et al (2015) suggests was that when service users are unable to access services due to family financial difficulties, they were more likely severed from the appropriate support of mental health services.

As already stated there is a higher incidence of schizophrenia in males, compared to females and this has particular significance in African context due to the nature of men's role in Africa and notions of masculinity. As Barker and Ricardo (2005) noted traditional views of gender describe a model of household relations, which embodies ideas about the role of the male as provider. A significant feature of gendered expectations, is in the idea, that men are expected to financially provide for family sustenance in many traditional African societies (Morrell and Ouzgane, 2005). However, this links in to the global literature on men, such as Pleck's (1995) gender role strain paradigm which raises concern that men's adhering or struggling to live-up to gendered expectations has impact on their health.

Given this context, it is perhaps understandable to focus on the men's perceptions and experiences of schizophrenia and role of gender within this. Furthermore, some studies in Africa, such as those carried out by Jewkes and Morrell (2010) and Odimegwu and Okemgbo (2008) have suggested that traditional notions of masculinity, has an impact on sexual health risks such as vulnerability to acquiring HIV/AIDS and health programs have been designed to address issues beneficial to these men and their partners. In contrast, there is a notable lack of

research on understanding of the role of gender and its impact on service users' perceptions and experiences of schizophrenia.

### 1.3 Aim of the research

The aim of this qualitative study was to explore the factors that influence men's recovery from schizophrenia in northern Nigeria.

### 1.4 Research questions

The two research questions in this study are:

- (1) What are perceptions and experiences of developing schizophrenia in Nigeria?
- (2) What factors influence recovery from schizophrenia in Nigeria?

### 1.5 Objectives of the research

The specific objectives of this study are:

- (1) To explore the perceptions and experiences about the causes of schizophrenia.
- (2) To examine the meanings of recovery.
- (3) To understand influences on men's recovery.

It was some of the questions above and in particular, my experiences relating to the above questions that led to the current study. In 2010, I carried out a qualitative study among psychiatric service users in the United Kingdom (Utblo, 2010). The study was conducted among outpatients attending a National Health Service (NHS) community health service in the north England. The study's participants were African men who were recovering from schizophrenia. The results from this Master's degree research showed a number of influences on service users' recovery. However, as will be discussed, the MSc study did not provide

understanding of contextual data on constructs and practices of masculinities and its implications for men's recovery. This generated my interest to start working in this area as part of understanding the factors that influence men's recovery.

The importance of the gaps in my post-graduate study in the United Kingdom and other studies in Nigeria was strengthened when I realised as White (2002) documented in Australia that "What men do, how they behave and how they related to others, impacts not only upon themselves but those around them as well" (pp. 268). Hence, there is a realisation that gender practice can play an important role in men's perceptions and experiences of schizophrenia. Yet, there was no detailed research done on men's perceptions of schizophrenia, and the role of gender in influencing their beliefs about recovery.

The current study provides insights into the implications of masculinities, on Nigerian participants' perceptions and experiences of schizophrenia from first symptoms through to recovery. It is hoped that results from this study will not only add to a body of knowledge on the impact of gender on participants' perceptions and experiences of schizophrenia, but also a broader understanding the changing nature of masculinity within the Nigerian context.

## 1.6 Structure of the thesis

In the body of this thesis, I explore experiences of developing schizophrenia and the factors that influence patients' recovery from the condition within northern Nigeria. The overall structure of the thesis including the introductory chapter takes the form of nine chapters.

In chapter two, a literature review on conceptual issues of gender is presented. The first part presents discussions on the meanings of gender. The second part of this chapter focuses on concepts of masculine expectations, which highlights how gender is practised in the family including marriage and work. The third part, discusses men's changing identity in modern Africa. This includes a discussion on post-colonialism in Nigeria, and the effects of the changing economic situation and introduction of gender policies. In the last section of this chapter, the literature and related discussion focuses on the impact of gender on men's health.

Chapter three presents a literature review and conceptual discussion relating to schizophrenia and its recovery. The first part presents approaches that have been employed in the diagnosis of schizophrenia and the burden associated with onset of the condition. The second part includes discussions relating to the causes of schizophrenia, such as whether it is predominately biological or dependent on religious-spiritual beliefs. In the section under recovery, the first part focuses on the definitions of recovery. Within the second part of the section on recovery, the discussion focuses on approaches to recovery from schizophrenia, highlighting the role of western psychiatry, religion and the importance of family support.



Chapter four outlines details about the methodology of the research and methods used. It starts with the methodological orientation of the study. It then outlines, the methods utilised including a discussion of my fieldwork experiences such as an account of the sampling approach. This chapter, further includes an overview of the study sample providing details of the study participants and how these participants were recruited. The conduct of the data collection during the fieldwork and the management of the interview sessions is discussed. In addition, I discuss the data analysis processes and the ethical considerations during the conduct of the research. The chapter ends with a reflexive account, which includes the impact of being a British citizen researching Nigeria.

Chapter five, is the first chapter of results and focusses on the theme of gender, where I discuss masculine expectations and the impact of gender in men's construction of their schizophrenia. In particular, this chapter discusses hegemonic masculinity in terms of traditional expectations constructed by the men. In doing so, it reveals the traditional male-headed family model in this northern community of Nigeria. Being head of the household was associated with marriage, work and provider of family financial needs, where these traditional male provider expectations reflects men's risks of developing schizophrenia. The finding reflected in this chapter also highlights the impact of changing gender expectations.

In chapter six, the men's views on the causes of their mental health difficulties are presented. These focused onto a biological theme, and their religious-spiritual beliefs. In biological beliefs, genetic heritability was recognised as possible cause. However, a religious-spiritual theme, attributing schizophrenia to God's will, ancestral spirits and Jinn possession was also present within the participants' accounts of the condition.

Chapter seven, focusses on the recovery theme, where the meanings of recovery from schizophrenia that emerged are discussed and these include, getting better, relief of symptoms associated with the condition and return to expected roles. The discussion within this chapter also provides insights into how the men were managing their recovery. In particular, this chapter discusses how the men viewed western psychiatry, religion and traditional sources. It also provides insights into the influence of family support and the importance of gender flexibility in men's recovery from mental health difficulty.

Chapter eight discusses the overall interpretations of the findings of the research. The discussion is oriented towards showing the impact of traditional views about gender. In particular, the pressure for a man as head of the household to oversee their family well-being in traditional Nigerian society was shown to be an additional factor affecting the men's risk of succumbing to an acute episode of schizophrenia. This section includes discussion on the influence of flexibility in gendered expectations as an emerging theme aiding the men's recovery. In addition, the chapter includes an integrative summary of the tensions that exist for men with schizophrenia in modern day Nigeria.

Finally, chapter nine summarises the findings relating to participants' beliefs about the possible causes of schizophrenia and the data in relation to factors that influence patients' recovery from the mental health difficulty. The implications of the findings of this study for practice, policy and the need for future research in the context of the conceptualisation of gender, and its impact on recovery from schizophrenia is discussed.

## CHAPTER TWO: LITERATURE REVIEW AND CONCEPTUAL DISCUSSION ON GENDER

### 2.1 Introduction

In this chapter, I review relevant literature on gender. The literature in the first section relates to meanings of gender, while the concepts of masculine behaviour such as the various spheres where gender is practised are presented in the second section. In the third section, the literature focuses on men's changing identity in contemporary African society including discussion of post-colonial healthcare in Nigeria. The last section of the chapter focusses on the role of gender in men's mental health, and highlights some of the reasons that heightens men's risk to health issues, including conceptual issues of how gender flexibility can be employed to understand men's health.

### 2.2 Meanings of gender

In the eighteenth century, the concept of gender evolved, but was generally merged within a biological sex differences between male and female (Eagly and Wood, 2012). However, as the World Health Organisation (2015b) suggests, while most people are born either male or female (biological sex), they are taught appropriate behaviours for man and woman, including how they should interact with others within households and which responsibilities they should assume in society (gender roles). As Eagly (2009) suggests, distinguishing gender from sex really began evolving at the end of the nineteenth century. This was in the era when the first wave of the feminist movement started questioning women's position in an industrial society. The increased wave of feminism almost a century later came to view gender as a practice that goes beyond being a biological male or female, where being a man or woman was not something that individuals are born with but rather something that is socially and culturally

learnt. Gender, then began to be distinguished from sex, to connote social expectations associated with appropriate behaviour for men and women (Risman and Davis, 2013). This implies that, men are expected to act the way they do because of ideals of masculine identity within a social and historic context. As Connell (1995) argued, there is a hegemonic masculinity, the culturally dominant form of masculine behaviour in any given place or time. By virtue of its dominance hegemonic masculinity defines men's expected behaviours in a particular society and individuals often strive to live up to these expectations.

### 2.3 Concepts of masculine expectations

David and Brannon (1976) provide insights into traditional masculinity. In their work, they categorised four basic tenets that seem to comprise the core requirements of traditional masculine identity in the United States of America. The most salient norm prescribes the avoidance of behaviours that are considered feminine, with the authors describing this as “no sissy stuff”. This relates to the distinction between male and female, where the two categories are viewed as binary opposites. This norm implies that in order to be real man, femininity have to be avoided. The second norm of achieving status is described as the “the big wheel”. This norm relates to the notion that men are expected to be successful, should be respected for their success and need to be looked up to. “The sturdy oak” constitutes the third norm relating to the cultivation of independence and self-confidence. According to this norm men should be tough and self-reliant. The final norm described by the authors in the phrase “give ‘em hell” and relates to the development of aggression. This norm prescribes that it is acceptable and even expected for men to resort to violence or be daring.

### 2.3.1 Men in the family

The practice of traditional masculinity associated with the family often reflects men's expected behaviour within the household. The key issues emerging is that men are expected to marry, have children, head the household and assume the position of breadwinner of their families. Vigoya, (2001) reviewed how some studies carried out in Latin America in the late 1980's and 1990's have approached the theme of men in the family. They reflect how in Latin America an important masculine identity was fatherhood because it is associated with being adult and the ability to be a breadwinner. This was also reflected in studies in Nicaragua (Sternberg, White and Hubley, 2007) and in Mexico (Wilson, 2003) where many felt that society expected being a husband, a father, a head of the household, and a breadwinner were important expectations of being a man. Similar constructions of masculine behaviour also emerged in the United States of America (Gavanas, 2004; Hobson, 2002; Nye, 2005) where men were traditionally expected to be fathers, head of the household and providers of their financial and material needs.

Within the African context, the findings reported in some studies carried out in Nigeria highlight the role of men in the family (Mudiare, 2013; Odimegwu and Okemgbo, 2008; Olawoye, et al., 2004). For instance, the study by Olawoye et al. (2004) which explored the societal expectations around masculinity found that the understanding of the role of men in family was similar, among three major ethnic groups in Nigeria. In that study, a total of 1,475 people were interviewed among the Hausa in the northern zone, the Igbo of south-east and the Yoruba of the south-west of the country, where the understanding of the role of men in family was similar, regardless of the locality or sex of the participants. The findings also suggest that men were often considered as the head of a family. The concept of headship embraces other attributes such as decision- making capabilities, as well as the ability to provide for the family and protect its members. Olawoye et al. (2004) also argued that the family context is where a

man's gender expectations are most clearly defined, by himself and by others. In this regard, the expectation associated with men as head of house includes financial provision for feeding, clothing and housing family members and expectations to provide financially for the medical bills of the family. In another Nigerian qualitative study, Odimegwu and Okemgbo (2008) explored gender expectations among participants in the south-eastern part of the country, where there was a predominance of traditional masculine beliefs among the participants. As in Olawoye et al's. (2004) study, the Nigerian societal expectations of man and responsibilities of the man as protector, provider and main breadwinner were clearly expressed by study participants in Odimegwu and Okemgbo's (2008) study.

Both the studies by Odimegwu and Okemgbo (2008) and Olawoye et al (2004) provide insights into how men in the home and community serve as role models. The role of men during the process by which male children acquire and retain male attitudes was reported to be largely practical. Father role models provide the practical example by their behaviour in the home and community. In addition, male children are actually shown, by direct instruction and devolution of authority and responsibilities, how to behave as a man. The socialisation of males among the Nigerian community is further manifested by folk stories told by the father role-model. Achebe (1958) in his influential work, "Things Fall Apart", provides several important descriptions of manhood in Igbo society as well as in Nigeria more generally. In "Things Fall Apart", Achebe's (1958) character Okonkwo is the head of the family who provides for his household. There are very high expectations from family members. Okonkwo acts this way in part to compensate for his own father's perceived weakness (his father Unoka died in debt and humiliation when Okonkwo was very young). Shame for Unoka and a fear of being a failure, forces Okonkwo to work tirelessly. This is another silent but rigorous schooling into gendered expectations that are ingrained into African males through gender role-model stories. Fathers tell their sons

stories of successful men to toughen them and prepare them for future roles as the head of their families.

These studies so far reviewed show that a man is traditionally regarded to be head of the family, in Nigerian context. This is also valid in other countries. As Cornwall (2005) suggests a significant feature of gender expectations, was in the idea, that men are expected to financially provide for family sustenance in many traditional African societies (Morrell and Ouzgane, 2005).

### 2.3.2 Marriage and fatherhood

To gendered African expectations, marriage is important because men were not only expected to marry but also to provide their wife with children (Appleton, et al., 2012; Graham and Mphaphul, 2015; Hendricks, Swartz and Bhana, 2010; Oyewumi, 2005; Ratele, 2011; Snow, Winter and Harlow, 2013; Temale, 2011).

In Nigeria, Uchendu's study (2007) explores the masculine views among undergraduates of the University of Nigeria, Nsukka. The students' ages ranged from 20 to 27. The ethnic groups represented were Igbo, Yoruba, Igala, and Ijaw. Uchendu (2007) reported the importance of marriage depicted through proverbs, for instance, one participant, an Igala, commented that an unmarried male adult is not yet a man ("Enekele du ki ma noyan che n eke le no"). Another participant, reflected this in a Yoruba statement that a man without responsibilities and challenges cannot call himself a man ("Eni ija koba kip e rare ni okunrin"). Uchendu (2007) also showed how, an Igbo proverb that a man without a wife is irresponsible ("okokporo n'enweghi nwunye bu ofeke") reflects of the cultural connection between a man having a

family composed at least of a wife and children and his masculinity. The ability to marry and father children became a basis for manhood because it facilitated an establishment of the family unit, so that a man can assume the headship of the household. Marriage was also reflected in Olawoye et al's. (2004) study where it was reported that - as in the Hausa of the north, and the Igbo of the south-east, marriage was an important fulfilment in the life of the Yoruba communities of south-west Nigeria. A qualitative study by Izugbara, Kabiru and Ezeh (2011) among men and women in Kano and Jigawa of northern Nigeria also reported the importance of marriage. An important reason for getting married and having children was that it brought honour. Izugbara, Kabiru and Ezeh (2011) similarly reported that an increasing proportion of men want to get married, so that they can commence headship of the family unit.

Oyewumi (2005) drew upon gendered practices in African societies such as in Ghana, Senegal, and Kenya, where almost every construction of gender that was reflected indicated that marriage, and having children were important expectations. This was similarly the finding reported in a study by Snow, Winter and Harlow (2013) which conducted interviews with men and women in the five African countries of Ethiopia, Rwanda, Tanzania, Uganda and Zambia. The findings of the study by Hendricks, Swartz and Bhana (2010) among twenty-seven young fathers between the age of fourteen and twenty years of age, in Kwa Zulu Natal, South Africa showed that young men desired to have children because they saw it as a man's lifetime achievement. The Hendricks, Swartz and Bhana (2010) study was conducted with the purpose of exploring the experiences and attitudes towards fatherhood, and the reasons that led to early fatherhood. Hendricks, Swartz and Bhana (2010) reported that young boys envied their young friends for their ability to have children. The impression that marriage and having children allowed men to demonstrate their leadership potentials in the family unit was reported as influential in the decision to marry.



The findings presented so far provide insight into African masculinity, showing the importance of the man as husband, where marriage, having children and household establishment is important.

### 2.3.3 Men as worker

Alongside men's role in the family, their ability to find employment was also important to societal gender expectations (Barker, 2005; Barker and Ricardo, 2005; Ratele, 2008). Having a job, earning a salary, or getting money by other means, has been argued, by Barker (2005) as a key expectations for being a man in many African countries and may even be a key feature of their identity. A number of studies have sought to explain this phenomenon. For example, the findings from Barker and Ricardo's (2005) multi-country study, among young men in Botswana, Nigeria, South Africa and Uganda, highlights the concept of being a man among young men, where having a job emerged as of high importance. Barker and Ricardo's (2005) found that an essential expectation before being considered a man is financial independence, employment or income, and starting a family. The emphasis on employment, was related to gender expectations in which there is a need for a source of income to support the household. Likewise, in Kwawu and Akan, southern Ghana, Miescher (2005) reported that men's access to cash became an increasingly important way to attain masculinity. Often closely related to this, is the emphasis on the male as financially responsible for the upkeep of the family.

It was evident that many men in traditional African societies were aware of the need of employment, and financial independence. In her work on the emergence of the idea of male breadwinner in colonial southwestern Nigeria, Lindsay (2007) maintains that this breadwinner ideal and being in employment arrived in Nigeria with colonialism. In South Africa, Hunter

(2005) reported that the introduction of wage labour by colonial settlers especially in the mines brought job opportunities for men. Both Lindsay (2007) and Hunter's (2005) studies conceded that men were aware of the multiple functions of employment and money. These studies reported that men by virtue of being employed and having an income assumed the breadwinning role and were seen as heads of their households. Ratele (2008) explored this issue whilst analysing expectations of males in South Africa. The author routes his examination of males through a number of categories including occupational and income attainment. The gendered experience of maleness, such as being in gainful employment was reflected as the need to support the household. However, Ratele (2008) pointed to the burden of gendered expectations and income attainment. He draws attention to the fact that unemployment and problems of having an income within African communities are severe. Therefore, a concern is that even though many men in traditional society are informed by an ethic of working hard for the sake of supporting the household, many of them find it difficult to achieve this due to unemployment concerns (Ratele, 2008).

## 2.4 Changing men's identity in modern Africa

In this section, the impact of Britain's colonial rule Nigerian society within the areas of education, work, and gender relations are discussed. Also, the review here highlights how British colonialism impacted on healthcare mainly through the introduction of Western medicine within Nigeria. The conceptual discussion therefore focuses on the consequences / critique of post-colonial western psychiatry, where the costs associated with western medicine emerged as a significant factor in its uptake.

### 2.4.1 Post-colonial development in Nigeria

Reviewing the related literature suggests that Britain's colonialism has a significant impact on the Nigerian society. For instance, Frankema's (2012) work exploring the impact of British colonial rule on educational attainment found that it heralded formal education. This formal education differed from the informal knowledge transfer involving extended families, which was common during the pre-colonial era, in the sense that children and adults congregated according to a predetermined weekly schedule in a classroom setting to engage in prescribed curricular activities. It is in this context, that formal education in within the Nigerian context, adhered to the organisational principles of Western education and gained popularity during the colonial era. As Nunn (2011) suggests across Africa, with the advent of British colonialism, the missionary and educational work resulted in the building of schools in many countries such as Ghana, and South Africa. Of key post-colonial significance is the increased educational attainment and how this related to new opportunities. Underlying this, as Cogneau and Moradi (2014) point out is the suggestion that during the colonial era missionary activity had long-term impacts on the level of education through a proliferation of primary schools established by different missions in Nigeria, Ghana and Togo. As the results of Cogneau and Moradi (2014) work also demonstrate, western education, meant these communities became equipped with new skills.

Shifts from traditional gender relations have been said to be related to colonialism. The Nigerian study by Omadjohwoefe (2011) explored this division of roles along gender lines, where it emerged sex role socialisation during the pre-colonial era witnessed a polarisation into gender suitable roles. When exploring dominant understandings of man's relative position in pre-colonial Nigerian society this was described as that of a man being the head of the household. Also, within the traditional family, the man was regarded as the breadwinner.

Similar results were found in Okonkwo's (2009) study of gender relations in the south-east part of Nigeria, where a common theme about pre-colonial era gender relations related to the distinction into male or female societal roles. Omadjohwoefe's (2011) observation about post-colonial gender relations mirrors those of Okonkwo (2009) where it was reported that gender relations still largely reflects the traditional characteristics existing during the pre-colonial, and colonial era, although, there has been an increasing transformation in contemporary gender relations.

Further engagement with the literature provides evidence, about the health impact of colonialism. For example, in the section on "Colonial War and Mental Disorders" in his publication "The Wretched of the Earth", Fanon (1963) presented case studies of a number of individuals with mental health difficulties, both Africans and French, who had been traumatised by the experiences in the Algerian revolt, arguing that colonialism affected mental health in relation to psychological violence of the colonial experience. It was also during his time at Blida-Joinville psychiatric hospital in Algeria, where he began to explore alternatives to western psychiatry such as establishment of non-drug therapy and open wards for the patients under his management.

Although, modelled on colonial western biomedical psychiatry, the newer post-colonial approaches to health care began to embrace local traditions of African-centred practices. For instance, Heaton (2013) goes on to describe the role of Nigerian psychiatrists in the early years of independence and the decolonisation of western psychiatry. Heaton's central focus in his work on decolonising psychiatry in Nigeria was Thomas Lambo, who studied medicine in the United Kingdom, and returned to Nigeria to establish the Aro Mental Hospital in 1954. As

Heaton (2013) noted Lambo's model of mental health care incorporated western psychiatry with non-western health frameworks. In doing so, the British-trained Lambo rejected notions of western superiority by including traditional healers at the Aro hospital to assist in the treatment and diagnosis of mental illness. Indeed, Lambo's approach, also, involved a community outreach program where patients stayed with foster families in the neighbouring villages. The Nigerianisation of western psychiatry by Lambo provides an example of a creative post-colonial health development for which independence provided greater scope. In Zimbabwe, Jackson's (1999) study adds to the body of evidence asserting the positive impact of post-colonial health sector development. In the psychiatric hospital "Ingutsheni", she observed that the colonial authorities operated race-based segregation on the wards, with one for Africans and another for Europeans. She point out that during 1966 to 1980, while the liberation struggle was being waged, David Nyathi sought to change this segregation. Nyathi was the first African to be trained and employed as a psychiatric nurse in Zimbabwe (Jackson, 1999). Having strong anticolonial tendencies, Nyathi brought the conditions at Ingutsheni to the attention of African political leaders. He arranged for them to visit Ingutsheni clandestinely one night. Appalled at what they saw, a parliamentary inquiry into the matter was initiated, putting an end to race-based segregation on the wards, and encouraging non-drug therapy (Jackson, 1999). Likewise, South African post-colonial mental healthcare as Kaliski (1992) stressed also faces challenges, to providing equitable non-racial care to all within the country. The findings of that study suggest that in most psychiatric institutions, healthcare during apartheid was race-segregated (Kaliski, 1992). It is from these instances, where psychiatry during apartheid is abused as an instrument of oppression, such as the involuntary hospitalisation of political dissidents. It is in this context, also, which post-colonial political intervention, has helped toward more equitable health care.

Although, as the above findings highlight healthcare in post-colonial era was transforming within Nigeria, a major challenge still facing post-colonial western psychiatry is the cost associated with its uptake. In a qualitative study examining the experience of patients with mental health difficulties, in a psychiatric hospital in Kaduna northern part of the country, Meshach, King and Fulton (2014) found that the experience of taking medication was associated with symptoms relief, which could affect the ability to function. However, the study also found that poverty affected the patient's abilities to afford these antipsychotics which were often described as expensive. This issue has also been reported by Effiong and Umoh (2015) in a study conducted in south Nigeria, to determine the prevalence of treatment non adherence in patients with schizophrenia and identify factors associated with it. Of the 132 out-patients who took part in that study, the prevalence of treatment non-adherence in this study was high showing that one in two patients were non-compliant with their medications. In terms of the cost of medications, the higher the cost of medication per day, the higher the rate of non-adherence. This was partly accounted for by the high proportion of participants who were unemployed. Osahon et al's. (2016) Nigerian study reviewed patients hospital records, and found that the antipsychotics prescribed included haloperidol, olanzapine and risperidone. As both Meshach et al. (2014) and Effiong and Umoh (2015) point out these medications, are very expensive and unaffordable to the majority of Nigerian patients.

Therefore, concerning alternatives, Akomolafe (2012) work on decolonising the notion of mental health problem and healing in Nigeria, raised concerns about colonial psychiatry marginalisation of African indigenous healing practices. Mental health and treatments he argued are shaped by Western hegemonic perspectives that are at odds with the beliefs and practices of culturally diverse groups, thereby creating a crisis for groups not represented by Western medical approach. Informed by the view that treating indigenous individuals from a

non-indigenous perspective is not only insensitive to local needs, but a subtle form of colonial oppression, he argued for the promotion of indigenous health frameworks. The implications of postcolonial paradigm for mental health care of indigenous local population he further argues is significant. In the Nigerian situation, for instance, Western-inspired concepts of mental health over non-Western or indigenous perspectives and the colonial invisibility of traditional approaches to health and well-being become untenable. It is in this regard that, the findings from the Nigerian studies conducted by Awodele et al. (2013) and Lifongo et al. (2014) which examined varieties of medicinal plants, suggest that the use of these products, not only provides some hope for revitalising the Nigerian traditional mental healthcare, but is also of relevance in addressing healthcare underdevelopment within the African context.

A number of conceptual issues emerged from post-colonial development within the Nigerian context. In the early 1900's commencing the British colonial era, the various kingdoms and empires that existed in the region during pre-colonial era were, united for administrative purposes into northern and southern Nigeria. Empirical studies have presented evidence that alongside education, job and gender relations, British colonialism has also had significant impact on the post-colonial health sector development of Nigerian society. In the first place, Britain's colonialism contributed to the commencement of formal education for Nigerian society. Before colonial intervention, knowledge involved learnings from informal spheres of the extended family, or through the tribal network. However, as Frankema (2012) point out Christian missions had arrived during the advent of British colonialisation and begun intensive missionary and educational work in Nigeria. Schools were built and the missions began meeting the overall formal educational needs of the people. The results are consistent with cross-country evidence of Nunn (2011) that under British colonial rule there was a proliferation of primary schools established by different missions and this had impacts on the level of

education as enrolment rates rose compared to the pre-colonial era. As Nunn (2011) suggests missionaries were especially prominent in promoting female education. Indeed, the rapidly expanding education in contemporary Nigerian society reflects evidence of this positive influence of British colonialism.

Another area showing the influence of British colonial education, relates to its impact on job opportunities for the Nigerian society. For instance, as Cogneau and Moradi (2014) observe this new missionary education prepared the community for new job opportunities, as teachers, church evangelists or pastors, clerks and interpreters. Prior to this, although occupations varied according to the geographical areas in Nigeria, the major ones were farming, trading, craft work, fishing, cattle rearing, wine tapping, and herbalist. Similarly, across Africa, in Ghana and Togo, Cogneau and Moradi (2014) point out that colonial education has helped individuals improve their life chances, and secure better occupation and income.

The contact men and women in Nigerian society had with British colonial settlers had an impact on gender relations. During the pre-colonial era, girls were often expected to stay at home to learn domestic roles such as cooking, and cleaning. As with the boys, the girls fit usefully into their society by learning almost exactly what their family trained them to do adapting to their role expectations. This then highlights what become seen as gender suitable occupations. However, as Omadjohwoefe (2011) argued during the colonial period there was a transformation within the Nigerian gender relations. There was a slight improvement regarding women's position in society. The introduction of western education by the missionaries opened up access for some women to acquire western education and become able to read and write. This enabled some of these females to be employed by the colonial administrators, as clerks or



teachers. By virtue of being employed some of these females began to complement their husbands in the breadwinning role and in some cases were seen as heads of their household. Post-colonial era transformations in gender relations continues to reflect the changing position of women in society Omadjohwoefe (2011).

Furthermore, with regards to the impact of Britain's colonialism on Nigerian healthcare, it is true to state that, although, there were health services during the pre-colonial period, these were within traditional approach, which emphasis the role of herbalist. However, the growth of western medicine, because of British colonialism, affected some traditional values of the Nigerian society. In this regard, the colonisation of Nigeria by Britain was an important factor in the emergence of biomedical practice. However, the introduction of western biomedical approach during the commencement of colonial rule in Nigeria, and indeed the post-colonial western psychiatry adopted within the Nigerian healthcare, can be criticised in relation to a lack of collaboration with traditional pre-colonial era healers.

In focussing this discussion on issues around post-colonial healthcare delivery within the Nigerian context, it is important to look back at the initial post-colonial health model developed by Thomas Lambo that was reflected in Heaton's (2013) work. The need to integrate recognisably competent traditional healers and some of their healing techniques is emphasised in Lambo's model of healthcare. In addition, a conceptual orientation has emerged from his mental healthcare approach. The orientation can be succinctly described as being "culture-oriented". This is because, this model, in contrast to western biomedical practice, stresses the role socio-cultural factors play in the onset of mental health difficulties and therefore has a strong bearing on the management of some people with mental health difficulties.

Despite recognition of the role, that traditional healers can play in meeting the healthcare needs of some people with traditional views, there has, been a departure from Lambo's collaborative approach. Indeed, with the abandonment of this approach, western medicine provision is now mainly hospital based. However, this brings to light another problem about post-colonial western psychiatry relating to the socio-economic circumstances of individuals and their willingness to embrace western psychiatry. For instance, many were without a source of income and so, irrespective of the cost of antipsychotics, they encountered much difficulty in purchasing their medication. Similarly, irrespective of distance from the hospital or pharmacy or the price of transportation, they were unable to pay, and this ultimately resulted in poor antipsychotic adherence. This line of argument then highlights the importance financial support could play in addressing the health needs of the population. As Osahon et al. (2016) maintained the development of social policy to include the waiving of prescription charges for individuals within this group would not only ensure that healthcare services are available, but would also actively contribute to improving healthcare outcomes of people with mental health difficulties.

It is becoming increasingly difficult to ignore the important role collaboration with traditional sources can bring to the maintenance of health within Nigerian society. For instance, the study by Awodele et al. (2013) found that alongside the management of mental health difficulties by biomedical psychiatry exists a traditional approach based on the use of plants. As in Awodele et al's. (2013) study, Lifongo et al. (2014) identified the plants used traditionally within these communities suggesting numerous varieties of medicinal plants. The varieties of medicinal plants in Nigerian communities referred to within the literature helps in understanding or even reflecting, the availability of traditional sources as alternatives to western medicine, especially in remote areas where clinics and hospitals are sparsely located.

#### 2.4.2 Impact of Structural Adjustment Programme (SAP)

Traditional Nigeria family systems are becoming transformed and this relates to the impact of the distressing economic situation. In 1985, the Nigerian Government succumbed to World Bank loan conditions through a structural adjustment programme (SAP). However, when SAP was imposed jobs diminished and many skilled men became unemployed via retrenchments and job cuts (Ammani, 2012). The challenge posed by socioeconomic changes on the traditional masculine roles was also witnessed across Africa. There were negative impacts of the SAP policies in Ghana, where Eduah (2014) found that the gold mines in the Tarkwa region of western Ghana lost many workers due to job cuts associated with the SAP. Economic insecurity has catalysed growing flexibility in gender divisions in Zambia. In 1983, a heavily indebted Zambian Government turned to the International Monetary Fund, which imposed economic restructuring such as job redundancies (Evans, 2014). However, as the findings from Evans (2014) study reveal, men with traditional gender views who previously opposed their wives going out to work, moved away from their earlier entrenched positions because of the economic difficulties. Harris (2012b) suggested that in Kaduna, northern Nigeria, some households were reinterpreting gender, due to the lack of men's steady employment that provided a living wage. Significantly, as Eboiyehi et al. (2016) observed within this context, the traditional concept of men as family breadwinners was challenged. The social expectations associated with the gender identity of men whose masculinity hinged on their sole ability to financially provide for their family became constrained as it became increasingly difficult to provide for their families. The need for financial survival, led to women becoming important for financial wellbeing. As a result, many traditional male earner or provider households were obliged to explore new household practices.

The impact of economic changes on gendered experiences was not unique to Nigeria but also occurred in other African countries (Agadjanian, 2005; Arnfred, 2004; Hunter, 2005; Morrell, 2001; Silberschmidt, 2005; Walker, 2005). In a study conducted in an urban area in Dar es Salaam and a rural area of Kissi in Kenya, Silberschmidt (2005) reported how implementation of the Structural Adjustment Programme (SAP) affected gendered expectations. In Kissi, a 1980 to mid-1990 survey of seven hundred and twenty three women and two hundred men was carried out. In Dar es Salaam, thirty-eight women and fifty-four men were interviewed. This study revealed high unemployment levels and a high cost of living affected men's gendered expectations as it became increasingly difficult for men to provide for their families. Further, Agadjanian's (2005) study provided similar insights on how high unemployment due to implementation of SAP resulted in high rural-urban migration but also how gendered experiences were challenged. In a sample of thirty-eight men in 1999, Agadjanian (2005) reported that due to increased unemployment men were joining their wives in street trading, an occupation previously associated only with women.

The above studies offered insights into the effects on gender relations of economic difficulties following the implementation of SAP. Men's gendered expectations were significantly constrained and fraught with difficulties resulting from economic hardships in the early 1980's. These studies also demonstrated how men in Nigeria and across a wider African context were reconstructing their gendered expectations. The nature of that new man represents a shift in attitudes in relation to the new environment that has been renegotiated by ongoing changes.

### 2.4.3 Introduction of gender policies

The implementation of economic programmes has had an impact on influencing traditional views of gender expectation. Alongside economic development, there have been policies instituted to promote equitable gender relations. Promoting gender equality is now globally seen as a development strategy that seeks to help women and men escape poverty, and improve their standard of living (World Health Organisation, 2013a). In Nigeria, the National Gender Policy produced by the Ministry of Women Affairs and Social Development, aimed to build a Nigerian society devoid of gender discrimination, that guarantees equal access to educational, political, and economic wealth creation opportunities (Federal Republic of Nigeria, 2006). As Nwoye (2013) points out, some Nigerian women, like their counterparts in other parts of Africa traditionally engage in domestic activities within the household. However, a significant factor influencing them to start a business is policy and institutional changes that remove the constraints to women's obtaining business financing. In this regard, the business links for women programs developed, joining new entrepreneurs with experienced business advisory agencies who provide advice on preparing business plans and applying for credits. Similar success in transforming gender relations was also reported in Rwanda by Promundo and Care Rwanda (2012). They assessed the impact of engaging men in village savings and loan programmes. This involves not only providing loans but also business skills, information on health and well-being, as well as information on gender issues (Promundo and Care Rwanda, 2012). In assessing the impact of the programmes, thirty female beneficiaries whose partners were involved in sixteen weekly group education sessions were compared with women who only received the training and loans without the involvement of partners. It was found that the women whose partners were engaged reported more income generated for the household, and improved relations with their partners. Also, in South Africa, legislation passed through the Commission of Gender Equality, sought to address gender equitable relations by promoting

wider participation of women in political and economic affairs (Morrell, Jewkes and Lindegger, 2012).

## 2.5 Gender and men's health

Findings in the literature often focused on the detrimental influence of traditional male role, where the concern is that men's adhering or struggling to live-up to social expectations has a negative impact on men's health. However, other literature highlights changing identities among household members and its positive influence on men's health. All this literature is reviewed below.

### 2.5.1 Hegemonic masculinity and men's health risks

A significant body of literature has addressed the negative influence of masculinity on men's health highlighting gender role perspectives. Theoretical explanations have predominantly focussed on the hazardous influences of the male role - the gendered expectations about what it means to be a man learnt from societal values. Harrison (1978) explains that the greater mortality rate of men is at least partially a consequence of the demands of the male role and emphasises the ways in which male-role expectations have a deleterious effect on men's lives, and possibly contribute to men's higher mortality rate. This position is demonstrated in Pleck's (1981, 1995) gender role strain paradigm, theorising masculinity in the context of men's enactment of masculine behaviours that in turn heighten their susceptibility to health issues. The traditional practice of gender was the basis of what Pleck (1981, 1995) referred to as the male gendered identity. He suggested this identity is the dominant concept of masculinity in society and is a source of problems, both for society and for individual men. Pleck (1981, 1995) argued that during the 1960s and 1970s, both men and women started to make significant departures from their traditional views as men began to behave in ways that violated the

traditional gender expectations. However, he also suggested that features of traditional male gender have retained a powerful influence over what both men and women believe men should be. He maintained that some deviate from gendered expectations, and that some even believe that the gendered expectations are harmful to them personally and to society, making adherence to male gender a strain.

Pleck (1981, 1995) recognised these effects of gendered experiences in his conceptualisation of gender and health problems. In dysfunctional strain, one of the kinds of strain mentioned, he implied that the fulfilment of gendered expectations can have negative consequences. Pleck's dysfunctional strain (1995) has the most theoretical relevance to men's health, because this implies negative outcomes from endorsing traditional views of male gender. He suggested a negative impact on men's health, of men's attempts to successfully meet gendered expectations. This hypothesis also has relevance as an impact on men's health, where men were struggling to fulfil gendered expectations associated with excessively detrimental efforts. In essence, the pressure is strong to live-up to this traditional view of gender. This could be what Goldberg (1976) meant when he discussed the hazards of being male, suggesting that the male gendered expectations may be dangerous to men's health.

However, Pleck's (1995) concept of discrepancy strain further hypothesised that not conforming to these traditional standards of masculine behaviour also has negative consequences for men. In particular, non-conformity to masculine expectations can result in feeling bad about oneself. Also, this inability to successfully meet gender expectations, has stressful consequences because of negative feedback as well as internalised detrimental self-judgments (Pleck 1995). In essence, men are expected to live-up to traditional expectations but

are seen as failure if they do not. This made men vulnerable he argued. This form of strain is therefore relevant in explaining the link between gender theory and men's susceptibility to ill-health.

The social construction of health issues, was also theorised in the early 1980s in the gender role conflict theory by O'Neil (1982). The author reviewed numerous situational contexts in which gender role conflict occurs. Suggesting that this experience is dependent on cultural specific definitions of gender, he argued that obsession with achievement and success explains men's preoccupation with work and reliance on their occupation to substantiate their sense of themselves as men. However, these obsessive fears of failure, resulting in workaholic behaviour, and increased stress, heighten health problems for men. Similar to Pleck's (1995) argument, O'Neil (1982, 2008) also suggested that men feel bad about themselves due to negative judgements from others as well as self-devaluation when deviating from, the attributes characteristic of traditional gender. As part of a qualitative examination by Beaglaioich, Sarma and Morrison (2013) of gender conflict among Irish adolescents, a sample of forty-one boys was recruited from six secondary schools in the Republic of Ireland. There was support for the O'Neil (1982, 2008) hypothesis among the Irish adolescent sample. Overwork and stress caused by the need to achieve in jobs or in school was found to affect men's health, and there were additional health impacts when being victimised or abused, through deviating from traditional gender views (Beaglaioich, Sarma and Morrison, 2013).

The idea of gender posing health risks through adhering to traditional views of being a man, was also reflected by Eisler and Skidmore (1987). They highlighted the concept of masculine gender stress, which refers to the cognitive appraisal of specific situations as stressful for men.



These situations include the individual's thoughts and behaviours, as well as societal expectations. For example, within traditional gender views, this implies that men will experience pressure when adhering to the expectations of a man. They may also experience pressure when they have been unable to cope with masculine expectations. Eisler and Skidmore's (1987) construction of gender and strains in men's lives could be particularly related to work situations such as being unemployed, and not making enough money, that also contributes to deviations from hegemonic masculinity.

Courtenay (2000) has also reported how traditional beliefs about masculinity in the United States of America that requires men to adopt risky or unhealthy behaviours. Theorising masculinity in the context of health he suggests that men experience comparatively greater social pressure than women to endorse gendered societal prescriptions such as strongly endorsed beliefs that men are independent, self-reliant, and strong. As Courtenay (2000) suggests, men's denial and disregard of health difficulties, and health care needs are a means to demonstrating their difference from women, who are presumed to embody these feminine characteristics. This denial also then serves both as proof of men's superiority over women and as proof of their ranking among real men (Courtenay, 2000).

The gender theories and conceptualisation of masculine strain in men's lives associated with traditional male role is not limited to the global North (Pleck, 1981, O'Neil, 1982, Eisler and Skidmore, 1987). Indeed, the construction of hegemonic masculinity within the African context also involves the division of household roles, the social definition of tasks as either "men's work" or "women's work," and the definition of some kinds of tasks as more masculine than others has health implications for men and it is to this we now turn.

### 2.5.2 Traditional African masculinity as a social issue

A significant body of literature provide insight into African masculinities including highlighting the importance of the man as head of the household. For instance, Morrell, and Ouzgane (2005) suggest that the hegemonic gender construct of man as household head, is predominantly related to expectations that men should financially provide for family sustenance in many traditional African societies. However, there is a concern that men's health issues have also been associated with struggling to live-up to gendered expectations.

The study by Somoye, Babalola and Adebawale (2015) among Nigerian workers in south-western communities has shed some light on the link between struggling to live-up to societal expectations and men's susceptibility to ill-health. This study found a male predominance in the workforce suggesting that traditional African society expects men go to work and to provide financially for the family. It was found that many of the workers were enduring long working hours and this cut across all job responsibilities. The working of long hours among the men, was associated with masculine expectations requiring them to provide the income for family sustenance, but was also identified as a risk factor for ill-health.

In traditional Nigerian society, whilst, being head of the household through being married becoming a husband and fathering children is highly desired, there is a view that men's fulfilment of this cultural expectation is also a source of worry for these men partly related to the costs of formalising marriage. Onyima (2015) explored this issue in detail, in a qualitative study of traditional marriage among the Igbo community of south-eastern Nigeria. The findings of this study revealed that many agreed traditional marriage rites should be performed before marriage is formalised. This is marked through the payment of bride price (dowry) by the man.

The union is then made public through traditional Igbo marriage ceremony (Igba-nkwu). The challenges, posed by this traditional concept of African marriage are reported to be high. In particular, men were believed to be struggling to meet the bride price and other costs associated with the marriage ceremony often meaning the family then go to their new home saddled with huge debts (Onyima, 2015).

The ability to meet these societal expectation associated with being a man in Nigerian context, are however constrained in view of the economic situation in Nigeria. Lindsay (2007) explored the emergence of the idea of the male breadwinner in south-western Nigeria. She found men's ability to find employment was an important gendered expectations where there is a need for a source of income to support the household. However, it was found that men's ability to meet this social roles was severally limited and was also a source of worry for these men who struggled to meet this gendered expectations.

The impact of this distressing economic situation on the attainment of masculine expectations is not limited to Nigeria, but representative of the kinds of tensions men were experiencing in other African countries. In Zambia, Dahlback et al (2003) conducted a study in the Lusaka and Kitwe communities, detailing how gendered expectations affected African males. The study showed that the reward for meeting gendered expectations is societal approval. However, one of the issues that also emerges, concerns the pressure to adhere to masculine expectations with some men going to excessively detrimental lengths to earn a living (Dahlback et al. 2003). Likewise in the eastern region of Ghana, Ampofo and Boateng (2011) reported how desire or pressure to conform to gendered expectations leads many of the men to high risk activities such as excessively long working hours. A multi-country study by Silberschmidt (2011) among

participants in Tanzania and Uganda, also, provide insights demonstrating how men were struggling to live up to such expectations due to economic difficulties. Because of this, they are likely to deviate from traditional gender roles and this seems to be a source of worry for these men.

Adherence to hegemonic constructs therefore has health implications for men in traditional African societies. Yet, there is also a body of literature that highlight the shame and ridicule of non-conformity to such gender beliefs providing insight into how a male in Nigeria who has attained marriageable age but has not taken a wife is devalued and this is also a potential source of ill-health.

Uchendu (2007) focused on how masculinity is defined in Nigeria and the effect of non-adherence to traditional gender beliefs. The perception of masculinity among participants in the study showed that marriage to a female partner was for many men, a means of exhibiting their competence to lead, because the man who successfully coordinates the affairs of his family is viewed as a successful leader in society. However, not all men showed the same level of masculine attainment. What emerges is some sort of devaluation of the unmarried male, because of the notion among majority of the participants that the unmarried adult male, is viewed as irresponsible in Nigeria's present political context, and excluded from vying for political appointments or holding a political office.

Cornwall (2003) also documents accounts of wives belittling husbands in the Yoruba communities of south-west Nigeria. It was noted that through the inability to meet family

demands many of these men were losing their respect. Cornwall (2003) suggested that this was evident when family members showed resentment of men's inability to financially provide for the household, through provoking arguments that sometimes ended in violence. This concern was also raised by Silberschmidt (1999) where similar poor relationships were witnessed in some households in the Kisii district of western Kenya. This was also mainly attributable to the inability of men to meet gendered expectations. Finally, strained relationships were reported by Harris (2012a) among the Acholi community in northern Uganda, where couples noted to be sleeping back to back and not having a sexual relationship due to husband's not providing financially for the household.

The traditional concept of gender therefore embodies specific views of male-provider roles, yet struggling to live-up to such role is associated with men's susceptibility to health risks, it is therefore important, as will be discussed next, to understand the nature of changing men's identity through the emerging concept of gender flexibility and its influence on men's health.

### 2.5.3 Gender flexibility and men's mental health

As suggested, the literature highlights change in gender that involves shifts from traditional notions of masculinity. One of the earliest approaches to understanding the changing nature of gender is reflected in Bem's (1974) androgyny concept. The Bem sex role inventory, developed masculinity and femininity scales to assess gender relationships with people who score high on the masculinity scale and low on the femininity scale were classified masculine, whereas people who score high on the femininity scale and low on the masculinity scale were considered feminine. However, Bem (1974) viewed people who score high on both scales as androgynous. Thus, whereas a narrowly masculine concept might inhibit behaviours that are viewed as

feminine, and a feminine self-concept might inhibit behaviours that are stereotyped as masculine, an androgynous concept highlight complementary, which is associated with the performance of masculine and feminine household tasks. As Anderson (2005) points out in a study which examined men's construction of gender in the United States of America, there is a transformation in the masculine/feminine binary, which is a feature of traditional gender. Anderson (2005) has described this emerging gender relations as inclusive masculinity. In that study, the emergence of this more inclusive form of masculinity is attributed to the men's willingness to participate in tasks traditionally defined as feminine and supported women who performed tasks traditionally defined as masculine. This included allowing themselves to be tossed into the air (flying), standing atop the shoulders of others, and wearing clothing defined as feminine. A similar dynamic was reported by Bridges and Pascoe (2014) in their concept of hybrid masculinities which also recognises the incorporation of elements of identity typically associated as feminine. The transformations in gendered behaviours by the emergence of hybrid masculinities, suggest that masculine behaviours associated with being a man were less differentiated from those of a woman. As such, Bridges and Pascoe's (2014) hybridity, like Anderson's (2005) inclusivity, not only reflects contemporary transformations in gender relations, but also can best be understood as emerging new, flexible identities and practices that challenges traditional fixed notions of gender expectations.

Within the health research literature there is need to focus on how the concept of gender flexibility can be employed to understand health. In a qualitative study, in the United States of America, Nicoleau et al. (2014) described gender flexibility in meeting household tasks as key to explaining why some families remain stable when faced with challenges such as how to meet the financial needs of the household. In that study, 21 heterosexual couples were interviewed to consider how flexibility is connected to the processes through which heterosexual couples

can maintain health. Their findings suggest that the ability to be flexible when confronted with changes in family circumstances has been recognised as characteristic of positive couple and family functioning. In the United Kingdom, Hauari and Hollingworth's study (2009) among 29 two-parent families which included Black African and Black Caribbean families, explored changing fatherhood. The findings suggests that even though in some families, some husbands expressed traditional gender beliefs, such as viewing man as the breadwinner providing income for family, many households roles were becoming flexible or interchangeable between mothers and fathers. The emergence of this flexibility in gender relation is attributed to wives' willingness to participate in tasks traditionally defined as masculine and supported their husbands who due to health difficulties could not performed tasks traditionally defined as masculine. The findings from Hauari and Hollingworth's (2009) study that suggests a transformation of fatherhood is ongoing are also consistent with those of Williams et al. (2013). In that study undertaken with 46 African and African Caribbean men in the United Kingdom, they identified how shifts from traditional ideals of the father as principally a breadwinner to one who shares responsibility with his partner also incorporated consideration in sharing responsibilities for ensuring the family's well-being. In developing a framework for understanding men's help seeking, Addis and Mahalik (2003) have proposed a conceptual framework that considers the influence of gender socialisation. Gender-role socialisation holds that social environments from the level of culture down to individual family and peer relationships teach men and women to display distinct sex-typed behaviours and attitudes. With regard to help-seeking for mental health problems, men may deny emotional pain or discomfort, as such behaviours allows them to preserve social status and to maintain gender expectations. Therefore, men may be disinclined to seek help if they believe their masculinity will be compromised.

Within the global South, this line of argument about gender shifts and transformation from traditional gender practice, is reflected in Nigerian studies. For instance, in a study of 233 households within the Yoruba community of south-west Nigeria, which explored roles in Nigerian families, Asiyanbola (2005) found that although the perception of the male as head of the household, where expectations of being the financial provider resonated, females were also involved in domains traditionally considered male areas, such as involvement in household financial needs. Most of the gender theorising in Asiyanbola's (2005) study is based on the assumption that increased levels of economic activity for married women would lead to some change in the traditional distribution of household expectations. Indeed, findings reported do suggest that, husbands share some of the household financial responsibility when their wives were engaged in paid work. Another significant study carried out by Ayenibiwo et al (2012) explored views about gender and household practices among students in two Nigerian universities. This mirrors the findings of Asiyanbola's study (2005) as household tasks were reported by participants to be flexible, rather than being fixed among members in traditional societies.

In Africa and particularly in Nigeria, the education of women was a significant factor highlighted in the study by Unterhalter et al. (2013). Here, some of the contextual factors that were preventing girls from achieving their desired level of education in the African context were being addressed, such as transformation in societal practices especially traditional attitudes towards early marriages were changing resulting in an increased opportunity for girls to enrol in public schools. Nwosu's (2012) study also explored the factors influencing the changing role of women in Nigerian society. Here, the choice of courses of study also had significance, with enrolment figures in departments of higher educational institutions in contemporary Nigeria showing rising female participation in previously male dominated



courses such as engineering. This follows through into new employment opportunities for women. Babalola and Akor's (2013) study explored the labour force participation of married women in northern Nigeria and examines the factors influencing the decision of adult married women to participate in labour force activities. The findings indicate that women's education has a positive effect on labour force participation. This then strengthens the importance of education in giving women the skills to venture into commercial enterprise and commerce-based private businesses and to participate in employment opportunities within industrial sectors. This has also been reported by Chuku (2015) and Oluwagbemi-Jacob and Chima (2015) where change in women's position in Nigerian society was shown to be associated with education which aided employment opportunities. Similarly, in Oluwatomiye et al's. (2015) Nigerian study which explored the growth of women's entrepreneurship in the northern area of the country. However, alongside education, their study revealed that the belief in *Purdah*- a religious practice in northern Nigeria where a woman's major household role is related to domestic sphere and therefore excludes women from female entrepreneurship is changing. Instead, their findings suggest that many women were receiving encouragement from their husbands to be entrepreneurs. Significant among the reasons cited for this was how increased opportunities for women engagement in businesses of their choice is important in meeting the household financial needs (Oluwatomiye et al. 2015).

Globally and in Nigeria in particular, there have been some significant changes in the political participation of women. For instance, Arowolo and Aluko (2010) explored political participation of women in Nigeria and showed how many participants believed in women's participation in politics, and were of the opinion that such participation is advantageous with work in government becoming a major source of employment. In the present administration women occupy strategic ministerial posts in Nigeria. Elsewhere, increased opportunities for

women's participation in the political arena, have also been made possible due to appointments into United Nations, such as that of Mrs Amina Mohammed (a Nigerian female) who currently serves as Deputy Secretary-General.

The importance of gender flexibility in the context of men's health is associated with household poverty reduction, and men's willingness to seek-help. The emerging transformation in gender imply that masculinity is being continually re-negotiated within a social context. Indeed, there are a newly emerging gender relations that are prompting a shift from culturally dominant societal expectations that are considered to represent traditional masculinity towards roles becoming interchangeable or complementary. In this regard, the redefinition of gender relations is associated with emerging opportunities for women to support in traditional male-provider household roles. This then is associated with household poverty reduction.

Furthermore, Oluwagbemi-Jacob and Chima (2015) explains that in the Igbo contemporary community of the south eastern area, there were increasing numbers of women who do not have one fixed gender identity given their involvement in multiple roles. By virtue of their success in commerce, these women were supporting their husbands, in making financial provisions for the health and well-being of their families. This recognition of Igbo women's participation in commerical activities and its impact on poverty reduction was also stressed by Chuku's (2015) work among communities in southeastern Nigeria. Detailing how traditional societal expectations associated with the role of man as the financial provider were changing, she explains that flexibility of gender relations allowed Igbo women to play a complementary role in meeting the financial needs of the family. This is because, women were excelling in commerce and dominated wholesale trade in such cassava products as gari. Admittedly, too,

as a result of the trading opportunities, some of Igbo women were reported to assume household responsibilities as family breadwinner.

It is this idea of poverty reduction, through flexibility in household gender relations, where women were increasingly complementing the men in meeting household needs, which is also of significance to men's willingness to help-seeking for their health issues. The hegemonic gender construct of man as household head are predominantly related to expectations that men should financially provide for family sustenance in many traditional societies both in the global North and South. When men and women were flexible around household roles, and embracing alternative model of gender relations, then provided the space for husbands to address health concerns or it aided pathways to recovery. For instance, in a qualitative study, among families in the United Kingdom, Hauari and Hollingworth (2009) describe how flexibility in household relationships between men and women was crucial in providing opportunities associated with the on-going health and well-being of a family member. Here, some husbands expressed hegemonic masculine beliefs, including construing being 'head' of the family as an important aspect of fatherhood. As such, some families valued traditional relationships, based around the notion of man as the breadwinner providing an income for the family. However, participants also talked about changing gender identities and gender dynamics. Because some husbands were unable to work, due to ill-health this affected their ability to provide financially for their families and some families then reported how wives had taken over the traditional male parenting role. For some families therefore, flexibility in household relationships, between men and women provided opportunities for household support that could be associated with the improved health and well-being of family members. It is reasonable to expect then, that the presence of gender flexibility, by household members, involving opportunities for women participation in meeting household financial needs, when the traditional male-provider

households were constrained, play a role in positively influencing men's respond to mental health issues such as the opportunity to seek help.

Even though women's position in society is changing, a major tension associated with the practice of gender flexibility both in the global North and South is whether through these social changes, women have additional burdens in taking on many or all of the household tasks. This is not necessarily the case, as households which adopt gender flexibility, compared to those with traditional expectations, are more likely to engage in complementary roles among all household members. In the Nigerian context, a study by Ayenibiowo et al (2012), examining household gender practices, shows that cooking and cleaning of the house, previously seen as appropriate domestics tasks performed frequently by women. Indeed, they were rather now perceived as appropriate for either male or female. Therefore, women were not just adding to their traditional domestic roles, rather the influence of gender flexibility was related more to how men and women mutually support each other.

## 2.6 Summary

In this chapter, I provided insights into the concepts associated with the practice of gender. The hegemonic gender construct of man as household head are predominantly related to expectations that men should financially provide for family sustenance in many traditional societies, both in the global North and South. There is a concern that men's health issues have been associated with struggling to live-up to such social expectations. However, social change has reconstructed some traditional gender beliefs and has resulted in some gains being made towards gender flexibility in household roles among family members. Significant among the social change that have contributed to changing positions and roles of both men and women was the influence of women's education and associated opportunities for women in employment and political participation. Households which adopt gender flexibility, compared to those with traditional expectations, are more likely to engage in complementary roles among household members. The flexibility in household gender relations where men and women were supporting each other, and being flexible around household expectant roles, has implications for men's health.

## CHAPTER THREE: LITERATURE REVIEW AND CONCEPTUAL DISCUSSION ON SCHIZOPHRENIA AND RECOVERY

### 3.1 Introduction

In this chapter, I review the literature around schizophrenia and recovery. In the section on schizophrenia, I discuss diagnosis of the condition, the burden associated with onset of mental health difficulties and approaches to conceptualising the cause of schizophrenia. The section on recovery focuses on the meanings of recovery including related literature around models of recovery, and discussion of the conceptual issues within these health approaches.

### 3.2 Diagnosis of schizophrenia

Toward the end of the nineteenth century, Kraepelin differentiated dementia praecox and manic-depressive psychoses (Kraepelin, 1919). Dementia praecox described individuals who showed a global disruption of perceptual and cognitive processes (dementia) and an early onset (praecox). Kraepelin's dementia praecox individuals usually had an illness onset in early adulthood. Among these individuals there is a progressively deteriorating course with no return to premorbid levels of function (Kraepelin, 1919). These features contrasted with the episodic nature of illness in individuals with manic-depressive psychoses, whose episodes also alternated with periods of normal function (Kraepelin, 1919).

Bleuler (1950) used Kraepelin's (1919) classification of psychoses to reformulate dementia praecox as schizophrenia from the Greek words for "splitting of the mind". He described four fundamental symptoms: ambivalence, disturbance of association, disturbance of affect, and a preference for fantasy over reality. As Bleuler (1950) argued, these symptoms reflected schizophrenia's fundamental defect: the separation or splitting of the normally integrated

functions that coordinate thought and behaviour. Kraepelin's (1919) views, however, connote an idea of a schizophrenic biological disease which begins in early adulthood, where there was no possibility of recovery. In contrast, Bleuler (1950) argued that it was splitting of the mind and that there were several possibilities for recovery.

Prior to the twentieth century there was no standard definition or classification of mental disorders. This posed a challenge to clinicians who had difficulty accurately diagnosing and treating schizophrenia. Although clinicians such as Kraepelin began characterizing mental illnesses such as schizophrenia in the early twentieth century, the Diagnostic and Statistical Manual of Mental Disorders (DSM) published in 1952 represented the first coordinated effort to create a diagnostic manual solely dedicated for use in psychiatric disorders. This was integrated with the International Classification of Diseases (ICD) published by the World Health Organization (Bhati, 2013; Moller, et al., 2015).

Both the DSM and ICD have undergone major revisions since first published, and the DSM-5 (American Psychiatric Association, 2013) and ICD-10 (World Health Organisation, 2010) now serve as the main clinical and research reference for diagnosing mental illnesses. The central factor in diagnosing schizophrenia is psychotic symptoms (Bhati, 2013; Morrison, 2014; Opler, et al., 2013; Yusuf and Nuhu, 2010), comprising two types, one of which is positive and one negative. In addition, a cognitive symptom has been seen in schizophrenia. Firstly, delusions, hallucinations, disorganised speech, and grossly disorganized or catatonic behaviour (abnormal behaviour) are positive symptoms. Mostly, there is a high percentage of patients with mental health difficulties who experience delusions and hallucinations. Commonly, delusions and hallucinations are outside of reality, for example, delusions are false beliefs, and hallucinations

are false sensory perceptions. Secondly, negative symptoms represent a losing of interest and motivation in life activities or withdrawal from activities. For example, not wanting to leave the house, being less likely to initiate conversations and feeling uncomfortable with people, or feeling there is nothing to say. Lastly, the cognitive symptom, impaired function, is related to the thinking process, for instance, difficulty in focusing, following instructions and poor memory.

The validity of the schizophrenia diagnosis in the Danish psychiatric central research register was carried out by Uggerby et al. (2013). A random sample of 300 service users with a first time diagnosis of schizophrenia in 2009 was drawn from the Danish psychiatric register to assess its validity. The case records were reviewed using the ICD-10 diagnostic criteria as reference. Many of the service users reviewed fulfilled the ICD-10 diagnostic criteria for schizophrenia. According to this assessment of service users' records, the diagnosis of schizophrenia ICD-10 diagnostic criteria has a high validity and is well-suited for research.

In Nigeria, Yusuf and Nuhu (2010) illustrate positive, negative and cognitive symptoms in schizophrenia diagnosis. The service user was 25 years old, unemployed and residing in a rural area of northern Nigeria. He was said to have been exhibiting abnormal behaviour. The illness was characterized by suspiciousness, talking alone, aimless wandering, and neglect of self-care. There also progressive deterioration of his relationships with his family and occupational functioning. On examination of his mental state he was dishevelled and exhibiting behaviour suggestive of a hallucinatory experience. He had delusional beliefs involving family members sucking his blood. Yusuf and Nuhu (2010) provide insights into the symptoms that are associated with schizophrenia.



Explanations for how schizophrenia may develop (Morrison, 2014; Opler, et al., 2013; Regier, et al., 2013) suggest that the condition may develop slowly. The first signs of schizophrenia, such as becoming socially withdrawn and unresponsive or experiencing changes in sleeping patterns, can be hard to identify. The negative symptoms of schizophrenia can also lead to relationship problems with friends and family because they can sometimes be mistaken for deliberate laziness or rudeness. However, people often have episodes of schizophrenia, during which their symptoms are particularly severe. This is known as acute schizophrenia, where drastic changes in behaviour may occur, followed by periods where they experience few or no positive symptoms.

In summary, schizophrenia within the medical model is a complex psychiatric disorder, for which researchers are trying to find out what the actual cause is to prevent the condition. Significantly, there could be a multiplicity of positive, negative and cognitive symptoms and assessment of these leads to diagnosing by mental health practitioners by use of DSM or ICD criteria. However, as will be discussed further, there are alternatives to biomedical explanations as the cause of schizophrenia.

### 3.3 Burden of schizophrenia

A first acute episode of schizophrenia can be very difficult to cope with, both for the person with the mental health difficulties, and for their family and health care providers. In a Nigerian study, Campbell et al. (2015) provide insights into the burden that is associated with schizophrenia. In that study, 100 people with a diagnosis of schizophrenia, who were recruited from the psychiatric outpatient clinic of Lagos University Teaching Hospital, Lagos showed a significant level of unemployment related to the presence of considerable symptom disruption. This finding is similar to what has been seen among people with schizophrenia in the United Kingdom (Knapp, Mangalore and Simon, 2004) where schizophrenia has been associated with an increased risk of unemployment.

The burden associated with schizophrenia was also reported to be costing the United Kingdom government an estimated three billion pounds in direct healthcare costs, as well as nearly two billion pounds in indirect costs through losses such as work productivity and absence (Knapp, Mangalore and Simon, 2004). In Nigeria, Ezenduka, Hyacinth and Ogonnia (2012) similarly suggested that the cost of one psychiatric inpatient admission averaged \$3675 including the costs of drugs and laboratory service. Information on the cost of mental health services represents schizophrenia as a significant public health concern, in terms of the health of individuals and the cost implications for those involved in their care. Alongside this, Lawal et al's. (2014) study explored the relationship between mental health difficulties and offending behaviour, and found a significant relationship between the condition and violent crimes in south-western Nigeria. The majority of offenders in their study, who had committed homicidal offences, such as murder, were found to be experiencing mental health difficulties. This information associating schizophrenia with violent crimes also highlights its significant public health concern.

### 3.4 Conceptualisation of the causes of schizophrenia

Within the literature, the exact cause of schizophrenia is unknown. Ikwuka et al's. (2014) study illustrates the dilemma in the conceptualisation of the cause of the condition. In that study, biological, psychosocial and supernatural beliefs about the cause of mental health difficulties among the Igbo people of south-east Nigeria were explored and findings suggest that the onset of mental health difficulties could be related to psychosocial life events. However, some participants expressed the view that biological factors, involving hereditary as possible cause to which schizophrenia could be attributed. The endorsements of biological and psychosocial factors, is indicative of a shift at the causal-category level from beliefs of a supernatural cause. However, supernatural beliefs about the cause of the mental health difficulty, such as possession by evil spirits were also expressed among the Nigeria society.

#### 3.4.1 Biological approach

A biological conceptualisation of the cause of schizophrenia (Harper, Towers-Evans and MacCabe, 2015; Kendler, 2015) involving hereditary/genetic susceptibility seems to have originated from family studies. In America, Heston's study (1966) compared the incidence of schizophrenia among forty-seven adopted children of women diagnosed with schizophrenia at Oregon State mental hospital with fifty children of non-diagnosed parents. The results showed that five of forty-seven adopted children whose biological mothers had schizophrenia subsequently developed schizophrenia. In contrast, schizophrenia was absent in fifty children of non-diagnosed parent. Heston (1966) argued that he had found evidence to support genetic predisposition to schizophrenia.

The influence of biological factors was also reported in other recent studies in America. In one study, Bagasra and Mackinem (2014) explored the views of 255 Muslim Americans regarding mental illness. Responses to questions about the causes of mental health problems reflect a general belief by the participants that the condition is a disease, and can therefore be perceived in a way similar to physical disease. Within the definition of mental health difficulties as a physical or medical condition, the most common theme that emerged was the condition as a dysfunction within the brain or a chemical imbalance in the brain. In Germany, the study by Wiesjahn et al. (2014) also discussed the assumption that a biological causal model can help service users to understand the nature of the disease and the relevance of anti-psychotic medications. Wiesjahn et al. (2014) conducted an online study of 84 participants with a self-reported psychotic disorder. Where it was reported that individuals who believe their condition to have biological causes, they also expressed views that it made sense to accept a biological treatment, such as the use of medication. This was also the explanation in Furnham and Igboaka's (2007) study where the conceptualisation of mental health difficulties as biological influenced their willingness to adopt western medicine.

This biological notion about schizophrenia was reflected in the Latin America countries of Bolivia, Chile, and Peru in a multi-national study by Alejandra et al (2015). The sample consisted of 253 service users and their carers recruited from mental health clinics, where examination of causal belief was conducted using three theoretically opposing beliefs systems: biological (schizophrenia is a brain disorder due in part to hereditary factors), psychosocial (schizophrenia is caused by external factors such as economic conditions, stressors) and magical-religious (schizophrenia originates from supernatural or spiritual forces). Alejandra et al. (2015) found that the biological factor was more frequently cited as a causal belief and that causal beliefs had implications for medications and severity of symptoms (Alejandra, et al.,

2015). Service users with higher levels of biological and psychosocial beliefs had reported significantly lower levels of symptoms. In contrast, higher levels of magical-religious beliefs were associated with increased symptoms and less favourable attitudes towards medications.

In Africa several studies (Bella, et al., 2012; Bulbulia and Laher, 2013; Issa, et al., 2008; Omoaregba, James and Eze, 2009; Parshotam and Joubert, 2015) reported similar biological causal beliefs among their study participants. In one study, Parshotam and Joubert (2015) sought the opinions of service users diagnosed with schizophrenia and a documented history of cannabis use regarding the effects of cannabis on their mental health. The study was conducted at Weskoppies psychiatric hospital in Pretoria, South Africa, among 60 inpatients, where the emergence of symptoms were implied by their use of drugs. This view was also reported by Issa et al. (2008) in a study conducted at University Teaching Hospital, Ilorin Nigeria, where alcohol and drug misuse were cited by the carers as possible causes of mental health difficulties.

In contrast to biological causal beliefs, related to alcohol and cannabis, other studies in Africa have also reported the attribution of mental illness to hereditary/genetic susceptibility (Bella, et al., 2012; Omoaregba, James and Eze, 2009). For instance, in south-west Nigeria, Bella et al. (2012) showed that young students aged ten to eighteen years held biological causal beliefs because they attributed mental illness to hereditary/genetic susceptibility. In another Nigeria study, among Nigerian families of the Ibo tribe, Omoaregba, James and Eze (2009) found that the risk of developing schizophrenia is higher among persons with an affected family member compared to the general population. Information concerning the family history of these participants was obtained from their mother.

Overall, the studies cited above suggest that biological factors played a crucial role in the perceptions and experiences of people with schizophrenia. In particular, there was the assumption that the risk of developing schizophrenia was higher among individuals with a family gene for schizophrenia. However, these studies also indicate other views about causal beliefs, because of this, there is a need for further examination of the causes of schizophrenia. The biological model has been conceptually critique by what became known as the Anti-psychiatry and it is to this we now turn.

### 3.4.2 Anti-psychiatry

Anti-psychiatry, a term first used by David Cooper in 1967, represented critical thinking and provided alternative understandings to western psychiatry. It emerged in the United Kingdom and elsewhere during the 1960s and 1970s. Cooper a South African born psychiatrist working in the United Kingdom at that time, questioned biomedical western psychiatry approaches, and the focus on medical explanations as the cause of mental health difficulties and therefore the use of medication for its management. One of the critiques that anti-psychiatry put forward was that psychiatric diagnosis was a problem not a solution. This line of argument is stressed in the work of Rosenhan (1973), an American psychologist. In his study 8 sane people, gained secret admission to 12 different hospitals in the United States of America. During their initial mental health assessment, they falsely claimed to be hearing voices. All were admitted and wrongly diagnosed with mental health difficulties. After admission, the false patients acted normally and told staff that they felt fine and no longer experienced hearing voices. However, all were required to admit to having a psychiatric condition and to agree to take antipsychotic drugs as a condition of their discharge. Laing (1960) is a prominent British anti-psychiatrist, whose views about the cause of mental health difficulties and its management also challenge western medical approaches. Laing's (1960) clinical experiences at the hospitals in the United

Kingdom, formed the basis for him to wonder to what extent the behaviour of the patients, most of whom suffered from schizophrenia, was the product of their social environment. He had observed that while, some patients after hospitalisation improved, over time some were readmitted. Laing (1960), suggests this demonstrates there was something wrong with the social environment that heightens the individual susceptibility to mental health conditions. With respect to the social underpinning to ill-health, Laing (1960) stressed the influence of society and particularly the role of family dysfunctional relationships stress generated by these this. He questioned the use of medication such as antipsychotics by psychiatry and instead suggested the choice of community approaches to care for people experiencing mental health difficulties. In 1965, Laing and his colleagues started Kingsley Hall, a community centre in east London which explored non-drug therapies for those with schizophrenia.

In his work, titled “the Myth of Mental Illness” Szasz (1960) an American psychiatrist, also questioned western notion of mental health difficulties, and the appropriateness of the medical model. He argued that mental health difficulties, were not a medical condition, but rather, within the contemporary social context, the finding of the condition is made by establishing a deviance in behaviour from certain psychosocial, and/or ethical norms. Szasz (1960) stressed that remedial action, tends to be sought in a medical framework, thus creating a situation in which psychosocial and ethical deviations are claimed to be correctible by medical action. However, since medical action is designed to correct only medical deviations, it seemed logically absurd to Szasz to expect that medical actions will help solve problems whose very existence had been defined and established on nonmedical grounds (Szasz, 1960).

A further theme in the anti-psychiatry critique relates to the view that psychiatric hospitalisations are often more damaging than helpful to patients, and opposition to such forms of treatments for the management of individuals also emerged. Goffman's (1961) ethnography work on asylums in the United States of America presents participant observation of the social situation of patients in psychiatric hospitals and how it affected their mental health recovery. The negative picture of the hospitalisation of patients by Goffman (1961) derives mainly from his use of the "total institution model". He described total institutions as places where large numbers of individuals are cut off from the wider society for a period of time and in this sense he likened psychiatric hospitals to prisons, and concentration camps which took over and confined a person's life within a dehumanising environment.

Goffman (1961) describes at length the "inmate world" of the total institution. Upon entering the institution, processes are set in motion to destroy the inmate's old self and create a new self. The person is dispossessed from normal social roles, stripped of his/her usual identity. There is a fundamental split between a large managed group, inmates, and a small supervisory staff. Total institutions greatly affect people's interactions, and human needs are handled in a bureaucratic and impersonal way. The social distance between inmates and staff is great, and each group tends to be hostile toward the other, with physical and social abuse being common (Goffman, 1961). Goffman (1961) also observed that contacts with outside persons were limited and inmates cannot prevent their visitors from seeing them in humiliating circumstances. One primary mode of adaptation of inmates in total institutions is "conversion," the adoption of the official or staff view of oneself and the acting out of the role of the perfect inmate. Similar to these views expressed by Goffman, Cooper (1967), in his publication, "Psychiatry and Anti-psychiatry" also observed that a major problem within these traditional settings of the hospital is that patients became "institutionally deformed" as they learned how



to act like a patient from those around them and to internalise the formal and informal rules of the hospital.

Similar to views expressed in “Asylum”, where Goffman (1961) highlighted dysfunctional consequences of institutional care, in Goffman’s (1963) theory of social stigma he emphasises the social disapproval associated with stigma. He describes stigma as the phenomenon whereby an individual with an attribute is deeply discredited by the society and rejected or devalued as a result of the attribute. Attributes associated with social stigma often vary depending on the contexts employed by society. Goffman (1963) gives the example of stigma associated with mental health difficulty because there is such a high degree of consensus to the effect that the condition presents a form of societal deviance and are a violation of norms or social expectations. In this situation, members of stigmatised groups may develop lower self-esteem than those of non-stigmatised groups, which in turn reinforces notions of chronicity in mental health condition.

Within the African context, in the Nigerian situation, critiques of the medical model of the form Goffman (1961) and Cooper (1967) observed also emerged. Sadowsky (1999) expressed concern about how western approaches, resulted in negative understandings of mental health difficulties within Nigerian society. For instance, he argued that, many of the patients confined at Yaba asylum, were identified to be suffering from what was called persecutory delusions, a diagnosis that Sadowsky (1999) notes was over-determined by the persecutory nature of western approach. Furthermore, his work, highlighted the problematic nature of the use of mental asylums in Nigeria, where individuals were reported to receive no appropriate care and

often lived in locked-up overcrowded cells with only rudimentary facilities for hygiene (Sadowsky, 1999).

Although, there has been criticism of the institutional model, the findings from other studies, highlight the mixed views of acute inpatient care. Jones et al., (2010) conducted interviews with 60 psychiatric inpatients in the United Kingdom, with a particular focus on their feelings of safety and security. Although, many inpatients felt safe and cared for in hospital, others, perceived psychiatric wards as risky environments. Some talked about being worried because of the way other service users looked at them, or because of their bizarre or aggressive behaviour. In another qualitative study among 13 patients in an acute ward, Stenhouse (2013) sought to understand the experience of being a patient on an acute psychiatric inpatient ward. Findings showed that the hospital was constructed as a place where people with health issues or in distress go to get better. Resonating with findings from Jones et al.'s (2010) study, participants experienced a sense of protection from the outside world when in the acute ward. However, this sense of protection was replaced by an experience of threat arising from perceptions of the other patients and their behaviour. The most commonly identified safety issues related not to direct physical safety, but to psychological safety, arising from the perceived threat, or fear of others, and the perceived lack of support from the hospital staff, which is also consistent with anti-psychiatry critique of the institutional model. However, in Nigeria, in response to some institutional care concerns, Aigbiremolen et al's. (2014) work highlighted, the concept of primary health care, as an alternatives that might help in achieving equitable health care for all Nigerians. Particularly noteworthy amongst these is the Ward Health System which utilises the electoral ward as the basic operational unit within which primary health care is delivered.

### 3.4.3 Psychosocial model

Late in the 1970's, a bio-psychosocial model for understanding the onset of schizophrenia emerged through the work of an American psychiatrist, George Engel (1977). An integral part of this model is recognising the role of life events and its influences in the emergence of schizophrenia. Thus, while, the biological approach is homogenous and reflects the global uniformity of schizophrenia, in contrast, Engel (1977) bio-psychosocial approach is heterogeneous, reflecting the diversity of individual experiences. Further support for this view came from Zubin and Spring's (1977) stress-vulnerability model where they suggested the idea of a "triggering hypothesis". This stress-vulnerability framework highlighted the effects of life events on the acute phase of schizophrenia and recognised life events as variables which can aggravate or precipitate a pre-existing vulnerability.

In the United Kingdom, some studies provide insight by showing the context of greater risk for African males (Fearon, et al., 2006; Keating, 2009; Robinson, Keating and Roberston, 2011). Fearon, et al. (2006) explored this issue in detail in the aetiology and ethnicity of schizophrenia and other psychoses (AESOP). The study took place in three areas in England: south-east London, Nottingham and Bristol. Each of the study areas have long-established African populations as well as other ethnic minority groups. Their study was inspired by some reports of an increased incidence of schizophrenia among Africans in the United Kingdom. Fearon et al. (2006) sought to clarify whether this increase was specific for schizophrenia and whether the incidence has also increased for other ethnic minority groups. Across the three centres, 568 cases of psychosis of people aged 16 to 64 years presenting to the services for the first time were scrutinised. Fearon et al. (2006) reported that all ethnic minority groups were at increased risk for all psychotic disorders, with black Africans found to be at an excessively high risk for schizophrenia compared to white British. In addition, Fearon et al. (2006) found that the

incidence of schizophrenia among African males was generally higher than the corresponding female rates for schizophrenia and other psychosis.

Keating (2009) reviews evidence of the context for greater risk for African and Caribbean men experiencing mental health difficulties. In particular, it seems that men from African and Caribbean backgrounds often find themselves in conditions and situations that are considered as risk factors for mental illness. They could have higher rates of unemployment, live in poorer housing, and have lower levels of academic achievement. In another study, Robinson, Keating and Roberston (2011) convened focus group discussions with black and minority ethnic men in various locations in London and the West Midlands. In that study, causal explanations for mental health difficulties indicate a mix of factors. Biological inheritance was deemed important. In addition, risk factors for the condition included gender expectations. It seems there were gendered pressures of the masculine expectations to provide for the needs of the family and this was partly related to the stressful effects of being unable to cope with aspects of daily life. As Freeman et al. (2013) and Goh and Agius (2010) suggest individuals carry genetic and other predisposition to mental health difficulties, however, this vulnerability in itself is not sufficient to manifest the symptoms related to the condition as this requires interaction with psychosocial stressors.

Some important risk factors for schizophrenia, other than purely genetic factors were explored in Europe (Selten and Cantor-Graae, 2005; Selten, Cantor-Graae and Kahn, 2007). Selten and Cantor-Graae (2005) have sought to identify the role and impact of life events, where they suggest that increased risk may be the result of defeat. Selten and Cantor-Graae (2005) argued that this type of defeat may be more frequent in immigrants whose notions concerning the

ability for upward mobility are thwarted by the opportunities currently available in Western societies. Selten, Canto-Graae and Kahn (2007) also reported higher risk of schizophrenia for migrants from countries where the majority of the population was black, particularly African groups. This increased risk they argue may be in response to environmental factors such as unemployment, and poor housing conditions.

Life events have also been reported as significant in the African context (Day et al., 1987; Gureje and Adewunmi, 1988). In a Nigerian study, Gureje and Adewunmi (1988) compared 42 first episode schizophrenic service users to an equal number of individuals without diagnosis of schizophrenia. Life event histories were taken for the six months before onset, and these were compared with equivalent histories from a psychiatrically healthy sample from the local general population. Their study provides some of the strongest evidence for a link between life events and the emergence of mental health difficulties symptoms. Life events were observed to cluster in the month previous to the onset of schizophrenia.

Collectively, these studies suggest that a single biological or genetic factor alone cannot explain the incidence of schizophrenia and highlight the critical role that life events factors appear to play in schizophrenia aetiology.

#### 3.4.4 Religious-spiritual beliefs

A review of the literature indicates that some people with mental health difficulties explain their condition within a religious-spiritual framework. For instance, Adepoju (2012) examined causal beliefs among African participants' in the United States of America, and found that a belief in God, referred to as "Olodumare", is common. This prevalent belief, was also found to be a strong influence in participants' explanations of how mental health difficulties arose. Likewise, in a study which explored lay beliefs regarding the cause of mental health difficulties in south-western Nigeria, Adewuya and Makanjuola (2008) found a widespread belief about the onset of the condition was being attributable to God's will. While the religious conceptualisation of schizophrenia was associated with the will of God, beliefs of possession by spirits about the cause of the condition also emerged.

In the United Kingdom, Khalifa et al. (2011) found that spirit possession was an important causal belief for mental health difficulties among their sample of Muslim participants recruited within Leicester community. In a previous study, Dein et al. (2008) also report on beliefs in Jinn possession among the Bangladeshi Islamic population of east London, in an ethnography study among 40 participants. Their study referred to the case of a participant who reported strange experiences like a doorbell ringing continuously, but no one would be at the door. The family consulted a local herbalist who diagnosed possession by Jinn spirit. A similar finding was reflected in Africa, where among fifteen service users interviewed in Mali, their symptoms of schizophrenia such as hearing voices were often explained in terms of local beliefs about Jinn possession (Napo et al. 2012). As the systematic review of the literature on Jinn carried out by Lim et al. (2015) highlights, that belief in the existence of Jinn is referred to in Quran, the Holy Book of Islam. This partly explains why the belief in Jinn is widely held in Islamic

communities, as well as among Islamic patients who have migrated to Western countries (Lim et al. 2015).

The belief in a spirit possession causation of mental health difficulties is also associated with ancestral spirits. This view is supported by Aghukwa's (2012) study which explored beliefs about the cause of mental health difficulties among Nigerian psychiatric patients and their families in northern part of the country. Findings showed that most patients and families expressed the belief of ancestral spirits as the cause of their mental health difficulties. In South Africa, Bojuwoye (2013) discusses causal beliefs associated with ancestral spirits and beliefs among the community that dead family members' transit into another world. In such instances, the burial signifies the beginning of a new life rather than the end. These explanations of the continuity of life after death also help explain its mental health influence. As living-dead, ancestors are believed to have supernatural powers. It is for this reason, that living family members gave food and drink offerings as tokens of respect, and appeasement for mental health. Bojuwoye (2013) argues that good acknowledgement of ancestral spirits is believed to translate to good will, such as achievement of desirable goals. In contrast, ancestors are also believed to be capable of inflicting mental health problems if they are displeased. Tatira (2014) reported similar findings among the Shona people in eastern Zimbabwe, where the experience of mental health problems by the vast majority of individuals was attributed to ancestral displeasure.

Other literature exploring the association of mental health difficulties as a condition brought on God and/or spirits possession suggests it could be regarded as positive due to its restraining effect on individual behaviours. For example, among traditional Nigerian societies, findings in

a study by Afe (2013) suggest that the association of mental health difficulties to God and ancestral displeasure helped facilitate the condemnation of incest. This association has been similarly noted in another Nigerian study by Omobola (2013) as having a restraining effect on some people's use of illicit substances. However, another issue with religious-spiritual causal beliefs as Audu et al. (2011) and Crabb (2012) found is the idea that mental health problems can be viewed as a moral lapse, or self-inflicted, therefore increasing social distance. In particular, findings from Crabb's (2012) study suggests that among the participants their experience of stigma was related to self-blame for their mental health difficulties attributed to illicit drug use.

Conceptualisation about the causes of schizophrenia are ongoing. While biological causal explanations highlight the influence of biological genetic susceptibility, this has been conceptually critiqued by anti-psychiatrists and those proposing a more social model understanding. These critiques suggest that a single biological factor alone cannot explain its incidence. Psychosocial factors and religious-spiritual conceptualisations associated to God's will and the possession by spirits also have been suggested as relevant in the aetiology of schizophrenia.



### 3.5 Definitions of recovery

The meaning of recovery reflected in studies carried out in Western countries (Ridgway, 2001; Spaniol, et al., 2002; Onken, et al., 2007) and in the African context (Adewuya and Makanjuola, 2009b; Gandi and Wai, 2010) refers to the processes of how individuals comes to terms with and overcomes the challenges associated with having a mental health problem.

The main drivers for the concept came from service users views particularly within the United States during the late 1980s and early 1990s (Ridgway, 2001). In a qualitative study, Ridgway (2001) explores service users meaning of recovery and suggests that each individual's journey to recovery could be understood as a personal process that involves the aspirations to re-establish, a valued sense of self. However, recovery is not linear, the journey is not made up of a specific succession of stages or accomplishments and does not follow a straight course (Ridgway, 2001). Instead recovery is an evolving process, one that sometimes spirals back, and may result in a return to illness after periods of positive functioning. As Deegan (1988) reports “at times our course is erratic and we falter, slide back, re-group and start again.” (p.15) Therefore setbacks or relapse are also part of the recovery journey.

In the United States, Spainol et al. (2002) explored the recovery process in some detail, highlighting different phases. Twelve individuals with a diagnosis of schizophrenia were purposively selected and each individual was followed for four years. Every four to eight months each person participated in interviews about current life experiences. Spainol et al. (2002) then described how experiences clustered into three broad phases of recovery: being over-whelmed by the illness, struggling-with the illness and living-with the illness.

Spainol et al. (2002) further argues that the over-whelmed by the illness phase begins around the time of the onset of mental illness and can last for months or for many years. This is representative of the acute phase. They argued that daily life can be a struggle mentally and physically. They reported that the majority of the participants tried to understand and control what was happening. However, because many at this phase felt confused, disconnected from the self and others, they were often unable to manage. The study also showed that there is a longing for connection with others, but also how established relationships with family and others are often fragile or non-existent. They demonstrated that new relationships can be very difficult to establish and that many participants were unable to articulate clear goals during this over-whelmed by illness phase.

Moving beyond the acute phase, Spainol et al. (2002) found that in the struggling-with the illness phase, there was recognition of the need to develop ways of coping. Medication was reported as helpful, but other coping strategies included sleeping, talking to a friend, cutting back on activities, or avoiding stress to manage symptoms. In the living-with the illness recovery phase, while the participants still felt limited by the illness, many had learned effective coping strategies. Because of this, Spaniol et al. (2002) reported that many of the participants assumed a number of meaningful social roles.

Spaniol et al. (2002) associated certain tasks with the process of recovery. One is developing an explanatory framework for understanding the experience of schizophrenia. While those at the beginning phase of recovery tended to have no clear explanation for their symptoms, those who were struggling-with or living-with the condition explained their experience in a variety of ways. These included an illness brought on by environmental stress, or trial presented by

God, or as a medically treatable condition. A second task of recovery, was to get some control over the illness, which required having the presence of various supports such as family, financial resources, stable housing, and collaborative relationships with mental health services. The third task of recovery was to move into roles that were meaningful, productive, and valued in the society at large (Spaniol et al., 2002).

Onken et al. (2007), also in the United States of America, provided useful insights into the definition of recovery. In their review about what recovery is or what its definition should entail, they emphasised that recovery is about change. Therefore, understanding recovery in this way indicates that recovery is not only limited to absence of symptoms, but included the restoration of important aspects of life (Onken et al. 2007). In this regard, recovery can be viewed as facilitated or impeded through the dynamic interplay of influences. As Topor, et al. (2011) show, this multifactorial view of recovery includes maintenance of family relationship, and participation in the community.

In the United Kingdom, Law and Morrison's study (2014) aimed to establish consensus about the meaning of recovery among individuals with experience of psychosis. A total of 381 service users gave their views. Recruitment took place across seven National Health Service (NHS) mental health trusts in the north-west of England. Regarding definitions of recovery, Law and Morrison (2014) reported that recovery is the achievement of a personally acceptable quality of life. In particular, this study associated recovery with feeling better about oneself, because of positive changes in life. Similarly, the item most frequently cited as essential or important to show that someone was recovering was when the person was able to find time to do the things they enjoyed. Law and Morrison (2014) also endorsed a number of factors which may

facilitate recovery, with environmental factors (such as a safe place to live) most often cited. However, the study reported that lack of services providing help would hinder recovery and that stigma was a barrier to recovery, as it affected important aspects of daily life such as being unable to gain employment.

In Nigeria, some studies (Adeponle, Whitely and Kirmayer, 2012; Adewuya and Makanjuola, 2009b; Gandhi and Wai, 2010) offer insights into the meaning of recovery. The study by Adewuya and Makanjuola (2009b) explored recovery among psychiatric service users at Obafemi Awolowo University Teaching Hospital, Ile-Ife. The World Health Organisation quality of life assessment questionnaire (World Health Organisation, 1996) was utilised. The study showed employment as helpful to recovery because it not only provided financial remunerations, but promoted self-esteem. Similarly, absence of support was reported as impeding recovery.

In another significant study, Gandhi and Wai (2010) utilised the Young and Bullock (2003) mental health recovery questionnaire to define recovery among service users at the Federal Neuro-psychiatric Hospital, Kaduna, Nigeria. Two hundred and thirty service users (inpatients and outpatients) were interviewed. The authors argued that recovery could be described as the process of successful coping. The partnership-in-coping interventions reported are multi-dimensional and multi-faceted and the authors suggest this should include bio-physiological coping related to medical interventions, particularly medication and nutrition. The study reported that cognitive-emotional coping has to do with psychological intervention, such as cognitive-behavioural therapy, while, Gandhi and Wai (2010) argued that environmental coping has to do with empowerment, and attainment of service users' goals.

Overall, the literature reviewed demonstrates the possibility of recovery. The subjective nature of recovery also means that individuals can emphasise different characteristics of recovery. As the World Health Organisation (2013b) suggested mental health recovery is a state of well-being in which the individual realises his or her own abilities, including being in employment, access to appropriate housing and community participation.

### 3.6 Approaches to recovery from schizophrenia

What constitutes recovery, or a recovery model, can be seen to be a matter of ongoing debate both in theory and in practice (Whitely 2010; Leamy et al. 2011; Slade, 2013; Law and Morrison, 2014). In general, professionalised clinical models tend to focus on improvement in particular symptoms and functions, and on the role of treatments. However, from the perspective of individuals, other writers (Adeponle, Whitely and Kirmayer, 2012; Adewuya and Makanjuola, 2009b; Gandhi and Wai, 2010) suggest that recovery may include helping with developing the skills to prevent relapse into further schizophrenia. Along with this, some service users tend to put more emphasis on rebuilding broken relationships or forging new ones, actively engaging in meaningful activities and taking steps to build a home and provide for themselves and their families (Boutillier et al., 2011).

#### 3.6.1 Western biomedical model

Although, recovery models lean toward different meanings, one approach to recovery that was identified is biomedical (Barkhof, et al., 2012; Heres, Lambert and Vauth, 2014; Lally and MacCabe, 2015; Ngui, Vasiliadis and Tempier, 2013). The biomedical model for recovery which is based on the use of anti-psychotic medication, has been associated with the treatment of schizophrenia. In this context, Ngui, Vasiliadis and Tempier's study (2013) in Canada has

reported how anti-psychotic medication has been associated with a decrease in symptoms in the acute phase. This study examined adherence rates to anti-psychotic medications over a two-year period in 8595 service users aged 14 years and older, registered with Saskatchewan Health who were taking an anti-psychotic medication. The main issues that emerged include the finding that risk of relapse is mitigated by anti-psychotic medication. As Ngui, Vasiliadis and Tempier (2013) suggest this risk increases immediately after stopping medication, while maintaining anti-psychotic treatment is associated with fewer hospitalizations.

In another study among mental health practitioners, Markowitz et al. (2014) emphasised the importance of anti-psychotic treatments among service users' with schizophrenia. The objectives of this study were to examine psychiatrists' views of the benefits and risks of anti-psychotic treatments for service users with schizophrenia. The results were based on 200 psychiatrists in the United States and 200 psychiatrists in the United Kingdom. The treatment of schizophrenia was assessed via a Web-based survey. Markowitz et al. (2014) suggest that psychiatrists found minimal improvement in severe positive symptoms. The findings were similar to those of other results in which reductions in positive symptoms and improvements in functioning were similarly recognised as important benefits of the anti-psychotic medication (Whitely, 2010; Liberman, 2012; Abubakar et al. 2013; Adelufosi et al 2013b; Ibrahim et al. 2015). These studies have shown how under western psychiatry, psychiatrists have used anti-psychotic treatments that have been shown to decrease symptoms in the acute phase and also to prevent symptom recurrence or relapse in the longer term. However, there were concerns about side effects in the use of anti-psychotic medications (Read, 2012; Oyekanmi et al. 2012; Teferra et al. 2013; Dodgen et al. 2015).

Within the Nigerian context, some have raised further concerns about poor financing (Dixon, et al., 2006; Ezenduka, Hyacinth and Ogbonnia 2012; Funk, et al., 2005; Gureje, et al., 2007; Jack-Ide, Uys and Middleton, 2013). Jack-Ide, Uys and Middleton's study (2013) explored mental health nurses' experiences of providing mental health services at Rumuigbo psychiatric Hospital, Nigeria. The majority of the twenty participants interviewed reported that the national health budget allocation is low. They suggest this may be due to a greater focus on treatment of infectious diseases as well as maternal and child health. However, this absence of appropriate financing contributes to poor care. In particular, participants observed that the current health policy required the hospital to generate funds for their running costs. Because of this, payment for services is required by service users and a large initial deposit is generally demanded before hospital admissions. Jack-Ide, Uys and Middleton (2013) argued that this hinders follow-up, and regular relapse has been noted as a result.

In terms of policy, the existing mental health policy document in Nigeria was formulated in 1991. It was the first policy addressing practice and management of mental health issues and its objectives include advocacy, promotion, prevention, treatment and rehabilitation (Federal Ministry of Health, 1991). Since its formulation, it seems that no revision has taken place and no formal assessment of how much it has been implemented has been conducted (World Health Organisation, 2006). This is likely to impact on the service delivery framework.

### 3.6.2 Religion and spirituality

The term traditional medicine as defined in the report by World Health Organisation (2013c) describes practices based on the beliefs, and experiences indigenous to different societies. In that report, the estimate of the world population relying on traditional healer for healthcare using medicinal plants, was around four billion people, mainly within developing countries. However, the findings reflected in the literature also highlight the important influence of religion involving the use of prayers in the maintenance of health. Underlying this, as Pargament (2001) point out is the suggestion that individuals take a relatively passive role in the resolution of health difficulties, trusting God to fully resolve the problem. Pargament (2001) has likened this type of religious coping to a “deferring approach”. A similar belief was expressed among the participants in the study by Corwin (2014) which explored the importance of a religious community in the United States of America. The findings of that study suggests that through prayers, individuals make request to God to elicit help in order to achieve improvements in their health difficulties. This view is supported by Krause’s (2014) study that examined Pentecostal healing prayers among Africans in the United Kingdom. The fieldwork in that study consisted of participant observation during church services involving deliverance prayer sessions as well as observations made when visiting people at home and interviews held with pastors in church settings. As in the study by Corwin (2014), many of the participants that took part in Krause’s (2014) study sought deliverance through prayers hoping that God will aid their recovery from health problems.

Although as highlighted above, prayers are an important religious coping practice for many people with health difficulties, the key problem with this explanation is that its usage also has negative implication. A total of 276 service users recruited from Switzerland, Canada, and the United States of America, were interviewed in the study by Mohr et al. (2012) which focused



on the role of spirituality and religion in outpatients with schizophrenia. The results of their study indicate that out-patients with schizophrenia often use religion in coping with their condition, basically positively, yet sometimes negatively. Mohr et al. (2012) found that religion is important for outpatients in each of the three country sites represented in their study, and religious involvement is higher among this group of people with mental health difficulties, than in the general population. Mohr et al (2012) also found that religious practice was helpful because it provided a positive sense of functioning. However, the study indicated that religion sometimes conflicted with psychiatric treatment. In particular, Mohr et al. (2012) reported that non-adherence to medication was an on-going obstacle in the treatment of participants with more religious beliefs. In a Nigerian study, Adewuya and Makanjuola (2009) explored the preferred treatment among the community where, those with religious conceptualisation of mental health difficulties preferred involvement of the local church or mosque such as through prayers, while those who significantly endorsed spiritual causes of the condition often sought help from herbalist involving sacrifices. However, in another study among Nigerian outpatients in a psychiatry hospital, Adeponle et al. (2007) described how promises of deliverance through prayers conflict with the use of mainstream mental health facilities. In particular, followers who attend for these prayer sessions while relying on promises of miraculous healings, are encouraged to disengage from use of psychiatric services (Adeponle et al., 2007).

Within the literature, the relatively disadvantaged socio-economic position of individuals has been cited as an explanation for the observed willingness to embrace religion and spirituality. Omotoye (2016) explored the socio-cultural factors that influence the use of religious and traditional spiritual sources in Nigerian communities. She observed that churches are springing up in every town and village in Nigeria. The churches founded or led by these “men of God” referred to as Pastors, are attended by highly educated as well by non-literate in the society.

The author was of the view that the community understandings of mental health difficulties underpin the widespread appeal of religious leaders and one of the features attracting people to the Aladura and Pentecostal churches. She added that across Africa, where many are suffering from socio-economic challenges of life, such as unemployment and poverty, people resort to religious leaders because they were more affordable compared to western medicine which was often decribed as expensive. This claim has been supported by other studies. For example, in a Ghana based study, Ibrahim et al. (2016) interviewed adult patients at a psychiatric hospital in order to explore their help-seeking behaviour. The findings of that study suggest that the decision to seek help is influenced by socioeconomic status such as their lack of health insurance. Likewise, the findings from Duthé et al.'s study (2016) in Burkina Faso, showed that access to medical care is unaffordable because majority of the people had no health insurance registration, they chose to access care at the non-psychiatric service providers.

Asamoah et al.'s (2014) study adds to the body of evidence asserting the positive effect of religion leaders on meeting the healthcare delivery in an African context. The sample comprised 20 clergy, from Pentecostal churches in Ghana exploring their experiences of working with people with mental health difficulties. Almost all of the Christian clergy interviewed expressed that a significant role they play as Pentecostal ministers in mental health care is the provision of certain basic needs for patients with mental health difficulties, lack of which might be the source of tension for these individuals. The religious leaders in Asamoah et al.'s (2014) study indicated that with some individuals, for instance, the problem is related to financial difficulty which adds to their distressed. This explains why religious leaders in that study offer financial assistance to those with mental health difficulties.

A further theme in the literature relate to the availability of religious leaders and traditional healers and the willingness of the vast majority of people to embrace religion and spirituality as an external locus of control over their lives. For example, in Ghana, a qualitative study by Ae-Ngibise et al. (2010) explored the reasons underpinning the widespread use and popularity of religion and traditional spirituality. When exploring dominant understandings of the causes of mental health difficulties, Ae-Ngibise et al. (2010) found that many participants understood the condition as a religious-spiritual phenomenon. It is thus clear that the mental health care of traditional healers and religious leaders are embedded within this wider belief. It also emerged in their study that the availability of religious and traditional sources is a contributing factor to their widespread use. A common theme amongst the participants' when talking about the appeal of traditional and faith healers was the easy access to such practitioners, practising in every community and in both rural and urban areas (Ae-Ngibise et al. 2010). Similar results were found in Khoury et al.'s (2012) study of treatment-seeking pathways for mental health difficulties where structural factors including scarcity of treatment resources created the greatest impediments to biomedical care for mental health concerns in rural Haiti.

Further engagement with the literature provide evidence that the delay in the commencement of treatment, following the onset of schizophrenia, is related to the pathways patients navigate before accessing mental health care. Odinka et al's. (2015) study assessed the influence of sociocultural factors on help-seeking behaviours among patients with schizophrenia at a psychiatric hospital in south-east Nigeria and their association with treatment delay. A majority of the 360 participants in that study had visited prayers and used religious leaders as their first treatment option despite many being educated. However, the findings of their study also indicate that the consultation with religious leaders often results in significant delays before patients present at the psychiatric clinic much later, when symptoms had worsened. Similar

findings were made by Adeosun et al. (2013) in a related study in south-west Nigeria. Their sample consisted of 138 patients with schizophrenia and the majority had initiated contact with traditional spiritual healers within one month after the onset of symptoms, while mainstream mental health services were not consulted until about nine months later. Indeed, the patients in Adeosun et al.'s study (2013) who first consulted general practitioners presented to an average of about one carer before presenting to mental health professionals, while the service users whose first contact was traditional healers or religious leaders saw an average of about six carers before presenting to mental health professionals. Ikwuka et al's (2016) exploration of the pathways to mental healthcare in south-eastern Nigeria also suggest that apart from lack of referral skills on the part of traditional spiritual care providers, delay is also exacerbated by the perception of referral as an admission of incompetence.

In contrast to the above findings, some research highlight a willingness of religious leaders and traditional healers to collaborate with modern medicine. In a Nigerian study, James et al (2014) explored a sample of clergy belonging to the Muslim and Christian faiths for their willingness to collaborate with mainstream mental health services. The findings of that study show that a large majority of clergy in their sample identified symptoms associated with schizophrenia. Also, a significant majority of the clergy in their survey expressed willingness to collaborate with mental health services such as referral to health professionals. In Ghana, Arias et al. (2016) examine the beliefs and practices of prayer camp staff and the views of biomedical care providers, with the aim of highlighting potential for partnership. Arias et al. (2016) conducted interviews with pastors and staff at Christian prayer camps in Ghana, and with health professionals within Ghanaian psychiatric hospitals. The results of their study show that prayer camp staff expressed interest in collaboration with biomedical mental health care providers, particularly if partnerships could provide clinical support introducing medications to those in

in the prayer camps. On the other hand, biomedical providers in Arias et al.'s (2016) study were concerned about the religious-spiritual interpretations of mental health difficulties held by religious leaders, however, expressed interest in engaging with prayer camps to expand access to clinical care for patients residing in these religious settings.

In their views regarding partnership, Leavey et al. (2012) suggest that the recognition and interpretation of mental health difficulties by religious leaders have important implications for patient pathways to appropriate care and their relationship with psychiatric services, compliance with treatment and outcomes. For instance, mental health problems identified as spiritual or religious in origin by clergy could lead to delays in reaching professional psychiatric help and/or difficulties in the patient's relationship with mental health workers. Therefore, Leavey et al. (2012) suggest that clergy willingness to accommodate biomedical explanations of condition, could be enhanced by health education. Similarly, religious patient's beliefs and experiences which could be negatively interpreted by mental health professionals could be enhanced through greater knowledge of patient's beliefs.

Despite its patronage, the older African spirituality practices are being criticised in relation to religion in some contemporary society. Omoleke (2013) raised concerns regarding the safety and effectiveness, of traditional herbalist practices, pointing out that very little clinical evidence exists concerning the quality of such methods. Furthermore, inadequate documentation, where practitioners rely mostly on memory makes such practices vulnerable to errors. Also modes of preparation are not very hygienic and there is the possibility of infection leading to toxicity. As Kanu's (2014) work on traditional African spirituality suggests the advent of religion, for instance has meant some modernity such as use of prayers which reflects transformation of the

primitive spiritual sacrifices. However, even though there are declining numbers of the followers of traditional spirituality, there are those that hold it will still be relevant. For instance, in the United Arab Emirates, Thomas et al. (2015) found that alongside the management of mental health problems by medical services exists a traditional approach based largely on Islamic sources. The practitioners of this traditional approach are known locally as Mutawa. The findings from that study suggests that the consultation of traditional sources for mental health related issues is widespread even with advanced medical health services.

Regarding the importance of religion and spiritualism in Nigeria, some conceptual issues emerged. In developing countries, including those in Africa many people initially seek care for their health needs from religious leaders such as Christian pastors, or Moslem imams and spiritual healers including the herbalists (Ikwuka et al., 2016, Ae-Ngibise et al., 2010). Prior to the arrival of western religion in Nigeria, the traditional practice was dominated by spirits worship. Societal problems were often thought to be caused by offending a spirit or ancestor. As Bojuwoye (2013) point out this meant sacrifices to the spirits were offered, consisting of slaughtering of sheep, goats, or fowls, each spirit having its appropriate sacrificial animal. The importance of the sacrificial ritual is to please these spirits with blood, for their protection and cures from difficulties. However, the growth of western religion, as a result of British colonialism, influenced some traditional values of the Nigerian society. As Kanu (2014) argues, on becoming a Christian, for instance, the traditional worship of spirits has been influenced by the belief of one God. Furthermore, the Christian missionaries' use of prayers, were replacements of the traditional spiritual sacrifices. With the gaining of independence in 1960 and in the post-colonial context, healthcare provision is largely hospital based, however the service distribution of these facilities are uneven. This created gaps in the healthcare delivery

approach. It is therefore becoming increasingly difficult to ignore the important role religion and spirituality play in the maintenance of health among the population.

The importance of religion and spirituality in the context of health can be considered in various ways. In the first place, their valued position in help-seeking are associated with religious or spiritual conceptualisation of mental health difficulties and the perceived need for religious or spiritual resolution of the condition. Therefore, religion and spirituality is of key importance among the Nigerian society because it links to their health beliefs. This observation was illustrated in southwest Nigeria, in the study by Adewuya and Makanjuola (2008) which explored lay beliefs regarding causes of mental health difficulties, where God's will have emerged as the religious explanation for condition. In contrast, results from another study in the northern part of the country, by Aghukwa (2012) reveal that Nigerian patients and their families expressed beliefs in ancestral spirits possession. Elsewhere, this view of possession by spirits as an explanation for mental health difficulties has also been reported by Khalifa et al. (2011) in their study among Muslim population of the United Kingdom where affliction by Jinn emerged. It is unsurprising therefore that the lay public believe care could best be obtained from non-medical sources. As in Adewuya and Makanjuola's (2009) study where preferred treatment among the Nigeria population was examined, those with religious conceptualisation of mental health difficulties preferred involvement of the local church or mosque such as through prayers, while those who significantly endorsed spiritual causes of the condition often sought help from herbalist involving sacrifices.

The use of prayers as an important feature of religion, plays a key role in a connection to God and the maintenance of a supportive relationship with a Higher Power. As Pargament (2001)

point out the presence of this connectedness instilled hope in God to help resolve their problems. This belief in God that things are going to get better motivate individuals to search for purpose in life going through really difficult times. However, the key problem with this approach is that it is not uncommon, for those who believe in God's deliverance through prayers to abstain from the use of medication. Among participants with schizophrenia in Switzerland, Canada and the United States of America, Mohr et al.(2012) discuss how many in their sample trusted God and through prayer sought help in the resolution of their mental health difficulties, however, the study findings also indicated that religion sometimes conflicted with adherence to medication. In a Nigerian study, Adeponle et al. (2007) described how it is rare to find a street without at least a prayer house or a home fellowship. In these religious places, prayer sessions with promises of miracles, and deliverances from various difficulties are a common, everyday occurrence. However, difficulties arise, when relying on miraculous healings, followers are challenged to believe in the reality of prayers, while being potentially encouraged to dissociate from the use of medications. Unfortunately, as the findings from Adeponle et al.'s (2007) study reveal, many of those who default biomedical care for prayer houses, usually much later, present to hospital emergency rooms and outpatient clinics in much worse conditions.

Another area that brings to light the important role of religion and spirituality, relate to the socio-economic circumstances of individuals and their willingness to embrace these religious practices. For instance, due to the limitations imposed by unemployment and poverty levels, the Nigerian public resort to religious and traditional sources as they are the only affordable means of health care, being a free service (Omotoye, 2016). Similarly, across Africa, in Ghana and Burkina Faso, both Ibrahim et al., (2016) and Duthé et al. (2016) respectively, point out that access to medical care is financially inaccessible because people do not have health



insurance to cover some of the costs which usually becomes a deterrent for individuals and families seeking such services. This line of argument then, highlight the important financial support role religious leaders' play in addressing the health needs of the population. The study by Asamoah et al (2014) examined the views of Christian pastors on the role of their churches in mental health care delivery in Ghana, where it emerged that some religious leaders offer some financial assistance to members of their congregation who are unable to afford it, which resulted in those people preferring to initially visit non-biomedical sources as their first pathway contact until they are able to afford money to go to the hospital. However, as the results of Asamoah et al's. (2014) study also demonstrate, the main barrier that mitigate against the roles of religious leaders in offering such support is that of inadequate funds.

In the majority of less developed countries, particularly those in Africa, including Nigeria, a major challenge facing mental healthcare is the shortage of mental health workers (Cooper, 2015). In the healthcare system, the majority of hospital-based western medicine are far located in urban areas, while the rural areas are mainly without such health services. Consequently, in the Nigerian context, many years after its introduction into the primary health care system, which forms the bedrock of Nigeria's health delivery, mental healthcare is significantly non-existent at this basic level. As Cooper (2015) highlighted one issue of particular concern is that a considerable number of people with mental health problems across Africa are not receiving care. Cooper's (2015) observation mirrors those of Khoury et al. (2012) where it was reported that the majority of rural Haiti do not have the option of choosing biomedical mental healthcare, and are seeking mental health treatment from Vodou systems of care. This is more out of limited options of the health system than a cultural belief in its effectiveness. However, one way of responding to this shortage is the wider engagement with religion and spirituality.

Religion and spirituality play complementary roles in addressing mental healthcare needs, among the Nigerian society, however, the problems arise when the symptoms are more acute and the delay causes greater misery for the individual and their families. In a qualitative study of Nigeria, Adeosun et al. (2013) found that patients who first consulted religious or traditional sources saw an average of about six care providers before presenting to mental health professionals, compared to an average of one care provider among those who first consulted a general practitioner. This delay has also been reported by Odinka et al (2015). Explanation for this adverse delay recognises the impact of health beliefs. This also play out because of the socio-economic circumstances of the individual. Furthermore, Ikwuka et al. (2016) suggest that apart from lack of referral skills on the part of traditional spiritual care providers, delay is also exacerbated by the perception of referral as an admission of incompetence. Although, this view point to a power dimension between the traditional local healers and the mainstream services, this claim has been contested. In their exploratory examination of Nigerian clergy willingness to collaborate with mainstream mental health services in managing mental health difficulties, James et al's. (2014) study found that many were comfortable referring an individual with symptoms indicative of a mental health problem to a psychiatric hospital. Also, in several of the prayer camps explored in Arias et al's. (2016) Ghanaian study, many of the staff described referral relationships with biomedical health professionals, where those patients living in the Christian prayer camps who were experiencing acute symptoms were sent to hospitals for medication. This then, strengthens the likelihood of partnerships with religious and traditional sources, where the involvement of the biomedical sector could impact on improving the care of patients with severe symptoms.

As time went on, the use of traditional African spiritualism, in contrast to religion, has suffered a decline in contemporary Nigeria. In this context of social desirability, as Omoleke (2013)

observed some practices associated with traditional spirituality are now believed to be primitive and not modern. This has led to its relegation to the background, while greater emphasis was placed on religion. However, even though the African traditional spirituality has undergone some decline following the influence of religion, both practices continue to be patronised by the people depending on their socio-cultural and economic situations. In the United Arab Emirates, substantial investments in health-care have ensured the widespread availability of medical services across the country. However, in spite of this accessibility traditional healers continue to play a significant role in health delivery (Thomas et al. 2015). This therefore suggests their continued relevance to the health needs of the vast majority. This view has been succinctly captured by Ae-Ngibise et al. (2010) in their qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care titled “Whether we like it or not people are going to them” to emphasise that as long as contemporary religious leaders and traditional healers practices are consistent with hegemonic cultural belief for mental health difficulties, these practitioners will be inevitably engaged in mental health-care delivery. The wider acceptability of religion and traditional practices among the Nigerian society is apart from the affordability and accessibility, due to their health beliefs which recognises their socio-cultural and religious background. As Leavey et al. (2012) suggests there is need for health education for both patients and those involved in their care, which will enhance understanding of how patients, their families and health professionals experience religion and spirituality and its impact on mental health.

### 3.6.3 Influence of family support

A family caregiver is defined as a relative or friend who provides unpaid assistance to a person who is unable to care for themselves due to illness, or other conditions (Askey, et al., 2009; Awad and Voruganti, 2008; Carers UK, 2010; Glick, Stekoll and Hays, 2011; Stansfeld, et al., 2014). Globally, family caregiving serves as a useful extension of the formal health care system, and their central role in community care is being acknowledged. For example, some of the literature indicate that family caregivers assist relatives with daily life activities such as getting food, bathing, laundry, going to the toilet and administering their medications (Abiama and Ifeagwazi, 2015; Awad and Voruganti, 2008; Carers UK, 2010; Glick, Stekoll and Hays, 2011; Lasebikan, Owoaje and Asuzu, 2012).

In the United States, for example, many service users requiring long-term care currently live at home or in the community, and literature suggests that unpaid family caregivers provide the majority of their care (Caquero-Urizar, et al., 2014; Gater, et al., 2015). In the United Kingdom, it is estimated that over six million people provide informal unpaid care (Stansfeld, et al., 2014). However, these can, for example, include dealing with difficult behaviours. The findings from their study also suggest that carers had an increased risk of having a common mental disorder. Carers were further reported to be more likely to report difficulties with debt and domestic violence (Stansfeld, et al., 2014).

In a study examining the relationship between family support and mental health recovery, Pernice-Duca (2010) found that the family often represented a primary source of support. Because the family was most often identified as a significant source of support, it is essential to understand how and why the family network support influences the recovery process. This study was based on 169 service users across 15 treatment programmes known as clubhouses. Clubhouses are community services which offer individuals opportunities to learn new skills

and socialise. Clubhouse participation is voluntary, but one must register and participants who participate in the programme identified at least one family member as part of their network of support.

This study helped to illuminate which aspects of the family support network were most important to the recovery of the person. Interventions that include family participation hasten the recovery process by assisting service users and their families to capitalise on ways to work together (Pernice-Duca, 2010). In this study, families were linked to their relative's willingness to attend a community mental health service. Receiving family support was also associated with taking part in tasks or activities around the house. Family participation was further an asset to their relative treatment process, as it provided a valuable source of information for the purposes of assessment and mental health practitioner care plan.

A similar position about the role of the family and improvement in treatment maintenance, adherence, was argued by Glick, Stekoll and Hays (2011). This study examined the relationship between treatment outcome and 2 family variables: their presence and their ability to support treatment adherence. Glick, Stekoll and Hays (2011) assessed 50 service users, and their families by dividing them into two groups. The first had a family/significant other, available and mostly supportive, to work collaboratively on adherence with the treatment team. The second group either did not have the family/significant other or, if they did, lacked support for long-term maintenance. Glick, Stekoll and Hays (2011) reported of the service users with available/supportive families, many remained in treatment for the full study course. In contrast, those who discontinued or dropped out, either did not have families or, if they had them, were unable to support adherence. In summary, having a family available and which is supportive

improves outcome through improving the long-term adherence to medication (Glick, Stekoll and Hays, 2011).

In Nigeria and other African countries, studies (Abiama and Ifeagwazi, 2015; Adeosun, 2013; Ae-Ngibise, et al., 2015; Ishola, 2013; Lasebikan, Owoaje and Asuzu, 2012; Sanuade and Boatemaa, 2015) demonstrate how family members make a significant and growing contribution to the care of a family member with mental illness. The results by Lasebikan, Owoaje and Asuzu (2012) suggest that families provide support to individuals to access services in Nigeria. This study was carried out in a psychiatric unit in a general hospital in Ibadan, Nigeria. Using structured questionnaires, data were collected from 652 service users on their family network, health behaviours and pathway to current service use. Lasebikan, Owoaje and Asuzu (2012) report that factors associated with mental health services' utilization were contact with either family or friends in general. Specifically, the findings from their study indicated that frequency of meeting relatives was directly related to service use, such that less frequent contact was associated with reduced odds of accessing health services (Lasebikan, Owoaje and Asuzu, 2012).

In another Nigerian study, Adeosun et al. (2013) reported that the tasks involved in rendering care to a family member with schizophrenia are enormous. The study was conducted at the out-patient clinic of the psychiatric hospital, Yaba, Nigeria. Data were obtained from 181 caregivers and 181 service users. The finding of this study highlights the protective nature of the multi-generational family system in Africa, where the task of caring for a family member is shared by a larger number of people beyond the typical nuclear family. Adeosun et al. (2013)

reported that the family were commonly looked to first when support was needed. In particular, the majority of service users were accompanied for their first visit to hospital by relatives, while relatives accompanying to the hospital, visiting at hospital after a relative was admitted were cited as important. A similar position was shown when discontinuation of visits or absence of family contributed to longer or indefinite hospital admission. Adeosun et al. (2013) added that when continued family contact is impossible, service users discharged from the hospital, were often unable to return home and became homeless.

Other studies (Adelufosi, et al., 2012; Adeponle, et al., 2009b; Adewuya, et al., 2009) have reported on the influence of family in facilitating a decrease in the number of relapses and hospitalizations of the patients. In one study, Adelufosi et al. (2012) assessed the reasons associated with medication adherence among 313 outpatients of a psychiatric clinic at Abeokuta, Nigeria. Adelufosi et al. (2012) suggest that participants who reported support from families and friends as being good were significantly more medication adherent compared with those who reported none. The findings of this study also suggest failure to adhere to prescribed anti-psychotic medications due to lack of family support has been associated with worsening of symptoms, and the deterioration of the relative's mental health.

The findings of other studies (Abiama and Ifeagwazi, 2015; Adewuya and Makanjuola, 2010; Igberase, et al., 2010; Ishola, 2013; Ohaeri, 2001; Yusuf, Nuhu and Akinbiyi, 2009) have also demonstrated that many service users had their treatments financed by family. Abiama and Ifeagwazi's (2015) interviewed 97 carers (relatives and friends of service users) recruited from the psychiatric unit of the University Teaching Hospital, Uyo and the Psychiatric Hospital Eket, Nigeria. Their ages ranged from 17 to 63 years. Findings indicated that relatives with high financial burdens may be responsible for purchasing medication or paying medical bills.

Abiama and Ifeagwazi's study (2015) also reported that the majority of family carers provides services including bathing, dressing, feeding, cooking and shopping for their relatives. Family carers were also reported to assist with running errands for, giving medicines to, and keeping company with their relatives.

In a Nigerian study, Yusuf, Nuhu and Akinbiyi (2009) highlight the importance of family support. The study participants were family carers of service users with schizophrenia attending the outpatient clinic of Katsina State Psychiatric Hospital. The hospital is a government health facility that provides both inpatient and outpatient mental health services to the entire population of Katsina state. The hospital also receives referrals from other states of Nigeria. One hundred and twenty nine primary carers of services users who had been on treatment for at least a year were interviewed. The objective of this study was to determine the nature of the burden reported by caregiving relatives of service users with schizophrenia. Most of the family carers were female. The level of burden experienced was significantly associated with place of residence. Family carers from rural areas were reported to be more likely to experience a high level of burden, compared with those from urban areas. One factor found to be associated with this, could be because of the additional burden associated with travelling long distances to access medical help for their relatives.

Ohaeri (2001) study on caregiver burden and service users' perception of support in a Nigerian setting argued that the tasks are likely to be more, because formal social security and welfare services for service users with schizophrenia are non-existent. Ohaeri (2001) suggests the lack of welfare systems of the type practised in western countries, may be responsible for the family as primary financial provider for relatives recovering from mental illness. Ohaeri (2001) also argued that community mental health services such as supported housing, and day care services



are also lacking. Therefore, the day-to-day care of the service users rests completely on available family members. Furthermore, Adewuya and Makanjuola, (2010) reported that the majority of the 99 outpatients attending the Obafemi Awolowo University Teaching Ile-Ife, Nigeria were unemployed. Adewuya and Makanjuola, (2010) argued this was the reason most service users were unable to meet costs of treatments. Also, because of service users' inability, Adewuya and Makanjuola (2010) reported that relatives were main financial providers and expected to make payments for mental health services for family members. Similar observations were made in Ae-Ngibise et al's. (2015) study among 70 carers of service users at Kintampo Health Centre in Ghana. The findings of that study reveal that only service users with a valid subscription to the Ghana National Health Insurance Scheme are able to access the services. However, many of carers were experiencing financial burden due to their socio-economic circumstances such as unemployment.

### 3.7 Summary

In this chapter, the literature about the causes of schizophrenia was explored where the idea of genetic heritability of schizophrenia emerged. However, this has been critiqued by anti-psychiatry. The role and impact of psychosocial factors were found to be important influences in triggering these causes. However, religious-spiritual beliefs about the causes of schizophrenia were also reflected in the literature. In terms of meanings of recovery, the literature engaged with described recovery as a process, involving symptom relief through use of medication and establishment of aspects of life valued by service users. The models found within the literature suggest that the influences on service user's recovery can be multifactorial and perhaps need to be considered collectively.

## CHAPTER FOUR: METHODOLOGY AND METHODS FOR RESEARCHING NIGERIAN PATIENTS RECOVERY FROM SCHIZOPHRENIA

### 4.1 Introduction

In the previous chapters I outlined the background to the research focussing on why this work is timely, what specific questions are being addressed by the current study, and the previous empirical work available in related areas. In this chapter, I discuss how the research was carried out and why it was carried out in this way. In doing so, this chapter initially examines the methodological issues involved in researching the factors that influence male patients' recovery from schizophrenia. It then proceeds to describe the specifics of the methods used and difficulties encountered. In this respect, the thesis maintains a differentiation between methodology, as the theoretical underpinning of the research strategy, and method, as the practical issues of sampling, data collection and analysis used. In the final section, I include a reflexive account, where I make explicit some of my own experiences which might impact on the research or even in the construction of the realities of people's everyday life.

### 4.2 Methodology

The methodological considerations in this research originate from within Berger and Luckman's (1991) social construction of reality. In line with this orientation, this section outlines some of the assumptions underpinning this framework and how these epistemological underpinnings have influenced the research design and /or methods used in this study. While the assumptions manifested by a social constructionist perspective may be varied, their work provides some useful insights into the most frequent or central of these assumptions.

In emphasising the importance of Berger and Luckman's (1991) work, this research proceed from within a theoretical framework which maintain that:

- i. As individuals seek understanding of the world in which they live, they develop subjective meanings of their experiences, and these meanings which directed towards social phenomenon are varied and multiple.
- ii. Often these subjective meanings are negotiated socially and historically. In other words they are formed through interactions with others and through historical and cultural norms that operate in individual lives.

These assumptions have also played a significant role in raising the importance of understanding experience as a valid and/or necessary way of gaining knowledge of the social environment. As we have seen, the presuppositions made by Berger and Luckman (1991), suggest that our view of the nature of social reality is greatly influenced by subjective meanings arising in and out of interactions within the human community. In adopting this stance, Crotty (1998) noted that human knowledge is given in society as an "a priori" relating to individual experiences and, providing the latter with its order of meaning. This order, although it is relative to a particular socio-historical situation, appears to the individual as the natural way of looking at the world. Crotty (1998) called this the "relative-natural world view" of a society, a concept that may still be regarded as central for the sociology of knowledge.

Such a theoretical foundation is relevant for research like this that is informed by my own academic experience and professional role as a health worker, yet also utilises research participants' experiences as the main form of data collection. For this research, this knowledge/theory/practice relationship has been present in several ways. First, it is my own academic experience and practice of health care work that generated awareness with previous

explanations about masculinity and health outcomes for men and therefore interest in the research topic. Second, it is the relationship between men's experience and practice of masculinity, and in particular the experience and practice of this for men recovering from schizophrenia, that forms an area of interest that this research will explore. Third, the relationship between health professional experience and the practice of health care work with men also forms a significant area of investigation in this research. Finally, through exploration of lay men and health workers views about recovery, a more adequate understanding of the interactions between masculinities, health and well-being is developed that can hopefully influence the nature of future practice in men's health work.

Furthermore, because of the importance attached to experience, there may be a difficulty for the researcher maintaining neutrality of the interpretive process. In other words, the knowledge that develops through social construction, is often through careful examination of data sets. As Creswell (2014) suggests, this involves a process of "co-construction" that recognises the subjectivities of both the researcher and the researched, and allows for a degree of identification between them. Also commenting on the importance of describing reality in this way, Crotty (1998) referred to the process as "mutual simultaneous shaping", where meanings are constructed and constantly re-constructed. This interpretive emphasis as Lincoln and Guba (1985) also noted, highlights the need for the qualitative researcher to take account of how their assumptions and views have impacted on the research process, in order to interpret the complexities of the multiple realities involved.

This research aims to understand men's constructions of schizophrenia and how this relates to how they manage their health. This stance therefore facilitated the inclusion of men living in a Nigerian community, as well as a significant influence on my decision to conduct the research in a natural setting of the study participants. Men living in their natural setting were therefore, selected who potentially possessed a range of characteristics that would provide examples of health care practices. As Guba and Lincoln (1985) suggests, research within a social constructivist underpinning may be conducted in a natural setting by the researcher, since the research context is integral to any meanings.

The appropriateness of utilising the purposive sampling method in this way rolls over to my choice of interview as the main data collection method. Mason (2002) highlights how this fits particularly well with a social constructivist orientation, since qualitative interviewing, "involves an interactional exchange of dialogue, being thematic, topic-centred or narrative" and operates from the premise that, as knowledge is situated and contextual, the purpose of the interview "is to ensure that the relevant contexts are brought into focus so that the situated knowledge can be produced" (pp.62). Put differently, the advantage of interviews was being able to explore the men's own views and experiences of the phenomenon being studied. For example, questioning during the interviews was predominantly broad and general allowing the men to construct their own meaning of their situation, through their discussions with me. As outlined in more detail later, this relationship with study participants resulted in the generation of in-depth data.

As I have pointed out, research informed through a social constructivist underpinning involves culturally derived and historically situated interpretations of the social life-world. Another

implication of this for this research, involves a commitment to a more formal process of analysis. Significantly, this offered me the opportunity to employ a sound analytic framework to the interview data generated in this way. Guba (1990) describes this process suggesting that the constructivist approach proceeds in ways that aim to identify the variety of constructions that exist and bring them into as much consensus as possible (p.26).

Having outlined the theoretical perspectives underpinning the research methodology it is important to turn to the specific issues of sampling, data collection and data analysis that constituted the research method and the relationship of these to the methodology.

### 4.3 Methods

Crotty (1998) defines research methods as “the techniques or procedures used to gather or analyse data related to some research question or hypothesis” (p.3). Although, there may be alternatives to the methods used in this qualitative study (such as those utilised in quantitative research), those adopted in this research are more appropriate in adhering to the methodology’s underlying theoretical perspectives. The following section discusses the key issues related to the research methods adopted, where I look specifically at how issues of sampling, data collection and data analysis actually progressed. The strengths and difficulties encountered in undertaking this research using these methods with the study participants are also discussed.

#### 4.3.1 Purposive sampling

The participants of this study were included through purposive sampling (Bryman, 2012; Creswell, 2014). Purposive sampling, as Creswell (2014) suggests, is a method of sampling in which the researcher has sufficient knowledge of the topic and includes a sample of appropriate individuals to contribute to the achievement of research questions. In this approach, the selection of participants, and settings is criterion based. Therefore, the sample are chosen because they have particular features or characteristics, which will enable detailed exploration and understanding of the central themes, and questions which the researcher wishes to study (Bryman, 2012). This was done in this current study by including individuals with experiences of schizophrenia that were decisive in explaining the phenomenon of recovery from the condition and those health care professionals that care for these men.

Purposive sampling is a particularly useful method here, because the aim of this research was to gain insights about the factors influencing men's recovery from schizophrenia. Therefore, purposively sampling a group of men with previous diagnosis of schizophrenia, and including healthcare professionals with experience of supporting these service users', helped me to identify common themes that have emerged about their recovery. The participants' inclusion and exclusion criteria are provided in the research protocol, which is included as appendix 1.

I started my fieldwork by organising a meeting and presenting the main purpose and approach of the study to the hospital staff where I gained useful insights and completed an induction into the hospital. The psychiatric hospital from which the sample is drawn is located within a community in the north-west zone of Nigeria. This is the largest of the six zones in Nigeria. A map of the six zones, which make up Nigeria, is included as appendix 2. This community (the

research setting) has a population of about six million people consisting of nearly equal numbers of males and females (National Population Census, 2006). The setting's population is also evenly divided between Christians and Muslims. The former consist of members of local tribes together with migrants from south Nigeria mainly Igbo and Yoruba. In contrast, the Muslims in this community are mainly of Hausa ethnicity. English is the official language, and the interviews were conducted in English, but a traditional brand of English known as "pidgin" is widely spoken.

#### 4.3.2 Overview of study sample

The research sample consists of 40 participants, made up of 30 patients and 10 hospital staff. Table 1 provides details of the participants which shows that the largest age group was aged 30 to 39 years. Those aged 20 to 29 years formed the second largest age group. Overall, the average age of the participants' was 33 years. The sex of the sample is made of 30 male patients, whilst the 10 hospital staff comprise 5 male and 5 females. In this study, a majority of the participants stated that they were employed. Religion was also spoken about with reference to the two types of religion practiced in Nigeria, namely Christianity and Islam. The majority of the participants who took part in this study is made up of 28 Christians, with 12 of Islamic religion.



TABLE 1: SOCIO-DEMOGRAPHIC DETAILS OF STUDY SAMPLE

	Male patients		Health professionals	
	No	%	No	%
<b>Age</b>				
20-29	11	36.7	1	10.0
30-39	13	43.3	6	60.0
40-49	5	16.7	3	30.0
50-59	1	3.3	-	-
<b>Sex</b>				
Male	30	100	5	50
Female	-	-	5	50
<b>Religion</b>				
Christian	24	80	4	40
Moslem	6	20	6	60
<b>Marital status</b>				
Married	18	60	8	80
Single	12	40	2	20
<b>Employment status</b>				
Employed	22	73.3	10	100
Retired	1	3.3	-	-
Student	4	13.3	-	-
Unemployed	3	10.1	-	-

The decision to recruit male patients as well as the inclusion of their health care professionals, as participants in this study, meant that I had to consider whether to include family carers. As Sandelowski (1995) suggests there is no minimum and maximum number for sample size in qualitative study. In this regard, Mason (2010) reviewed sample size used in PhD studies that have used interviews as their source of data collection. Results showed that when she looked at the abstracts of doctoral thesis relating to interview-based qualitative studies, the most common range for sample size were between 20 and 30. Also, on what is expected in terms of sample size for studies drawing on interviews, Braun and Clarke (2013) suggest that a sample

size of between 15 and 30 should allow for thorough examination to distinguish conceptual issues that address the research questions.

As the literature above suggests, the sample size in this current study was determined on the basis of what was considered appropriate for qualitative research. How many cases to include is a question that requires some consideration at the start of the research process. The answer to the question of how many participants at the outset of the research process comes, in large part, from the need to indicate an appropriate sample size in research proposals being prepared for Ethics committees. In specifying the proposed sample size, it was necessary to demonstrate to the Ethics committees' what is reasonable in terms of the right number. Baker and Edwards (2012) point out that all researchers have to scale their plans and expectations to the realities of their time and resources. Indeed, when considering the length of time research often takes, the difficulties of gaining access to study population, and in transcribing hours of interviews, they concluded that the size of the sample is generally influenced by the researchers' time available for data-gathering. Also, Robinson (2014) observed that the practical reality of research is that most studies require a provisional decision on sample size at the initial design stage. Without a provisional number at the design stage, the duration and required resource-allocation of the project cannot be ascertained, and that makes planning all but impossible. As both Baker and Edwards (2012) and Robinson (2014) maintained the time-frame and budget, can impose limits on the total number of participants that could be included. Even though there were time-frame, and constraints of money, I conducted this project within an adequate sample size considered appropriate within qualitative study. With a total sample of 40 participants in my study, the sample size is relatively large by qualitative standards. However, as the literature indicates, it is not about size, rather as evident in my study, a reader engaging with its finding,

can understand the relevant conceptual issues that illuminate how a sample of Nigerian men with mental health difficulties were managing their recovery from the condition.

#### 4.3.3 Recruitment of participants

Potential participants' who attend the psychiatric hospital outpatients' clinics were approached by a psychiatrist for initial invitation to take part in the study. They were given an initial letter (see appendix 3) inviting them to take part, along with the participant information sheet (enclosed as appendix 4) explaining the study (what the research is about, why it is being undertaken and explanations of participant role).

Those who agreed to take part were asked to return the reply slip (attached as appendix 5) to the researcher in the pre-paid envelope provided. I then made contact to further discuss the study, answer any questions, and arrange a suitable time for an interview. Written consent (attached as appendix 6) was then obtained before the commencement of an interview. Some of the questions and topics areas covered during the interviews are included as the interview guide provided as appendix 7. As it was important for the male participants, as much as possible, to tell their own stories this was used as a guide rather than as a set of direct questions to be adhered to and this is discussed further in the next section.

To ensure successful recruitment of the health professionals in this study, a meeting was held with the hospital staff, where I explained to them, that having spoken to the male service users, it became apparent how staff influences their experiences and therefore the study warrants expansion to also consider the views of hospital staff. This also enabled me to build up trust

and develop rapport with the hospital staff at an early stage in the research process. As the work by Walls et al. (2010) suggest discussion between the researcher and clinicians can help ensure they are clear about study aims, thus aiding recruitment.

There were no significant amendments to the recruitment pack to the hospital staff, where the first approach to hospital staff to take part in the study came from the psychiatrist, and the health professionals were invited to take part in the study through an invitation letter. Potential hospital staff signalled their interest in taking part in the study by sending a reply-slip, which was part of the recruitment pack in a stamped addressed envelope to me. Upon contacting the health professionals, I found that many of them appeared to have read the written information such as the participant information sheet before returning the reply-slip. In many cases, predominantly with the hospital staff, there appeared to be more understanding of their involvement in the study, which aided their recruitment.

#### 4.3.4 Data collection

This study used individual interviews as the data collection method. Within the literature, it is evident that interviews are a standard part of qualitative research. An interview within this context, is understood as a conversation with a purpose (Berg and Howard, 2014). As a conversation between two or more people, Kvale (2007) suggests that it has a goal of getting a participant to talk openly about their own experiences and perspectives. The purpose is to obtain their understanding and experiences of the concepts relating to the topic being covered. In this context, Rubin and Rubin (2012) described a model of qualitative interviewing as emphasizing the relativism of culture, the active participation of the interviewer, and the importance of giving the interviewee a voice.

The prevalence of interviews suggests that we live in an “interview society”. This term, coined by Silverman (2015), signifies that we live in a society in which interviews seem central to making sense of our lives and the lives of others. In such a society, interviews are perhaps the most familiar data collection tool for qualitative researchers. As Gubrium and Holstein (2002) commented, in an interview society, qualitative researchers make the assumption that when participants are asked questions during the interview process by the researcher useful information is elicited. This information then helps illuminate possible explanations to help answer the research questions (Gubrium and Holstein, 2002).

This could be the idea behind the comment by Miller and Glassner (2011) about multiple perspectives emerging in interviews. They explored the relationship between the story and the teller, suggesting that when participants construct their narratives in this way they provide insights into phenomenon being addressed. As qualitative researcher Weiss (1994) puts it in

learning from strangers the art and method of qualitative interview studies, “To talk to someone who listens, and listens closely, can be valuable, because one’s own experience, through the process of being voiced and shared, is validated” (p.122).

I shall now discuss how I managed the interviews with the male service users’ and the health professionals interviewed in the study. As I was planning this study, I felt a great deal of scepticism about whether it was actually possible to persuade these men in Nigeria to talk about issues of very personal psychiatric concerns. However, I found some literature (MacKinnon, Michels and Buckley, 2009; Oliffe and Mroz, 2005) which enhanced my understanding of the methodological and practical issues involved in interviewing participants of this nature.

From reading one of the examples of literature, Mackinnon, Michels and Buckley (2009), I became more aware of the challenges that might affect the interview sessions with people who use psychiatric services. These challenges include those that can be categorized as participant related. With this in mind, I felt that participants might feel ashamed or reluctant to discuss issues because of the fear of being judged. Because of this, it is possible that these men may give brief answers without much depth to questions. This could result in the phenomenon under study not being discussed in any great detail, affecting the quality of data collected.

It is in light of this, that I felt I had to work hard to persuade participants to talk. However, in another related example of the literature, Oliffe and Mroz (2005) share their experiences of conducting qualitative research interviews with men about health and illness. They offer practical advice for researchers on how to engage men in qualitative research. Their literature

is very important, offering advice on how to manage interviews with men. As their work suggests, participants may feel they are under examination or scrutiny and so not feel comfortable in relaying their experiences or telling their stories to researchers. Thus, I found it particularly important to reassure participants of this study from the beginning of the interview, explaining that there were no wrong answers or views, and that I was interested to hear about their perspectives and experiences. I found this approach of reassuring male service users from the beginning of the interview, worked well with the hospital staff too, where some of them might have felt more comfortable and these did open up in response to my questions.

Turning to the issue of establishing a comfortable space for the interviews. I feel another reason why there were high levels of disclosure may have been because the physical settings themselves were conducive to talking. The individual face-to-face interviews took place in a private room at the hospital and there were refreshments and toilet facilities. As has been noted by Opdenakker (2006) enabling participants to relate their narratives in a manner in which they felt comfortable aids rapport building and performance within the interview.

In order to collect data during the interviews, I had to have a method of recording interview conversations. As Patton (2015), advised, a good hammer is essential to fine carpentry, so a good recording device is essential to good fieldwork. He cited an example of transcribers at one university, where some of the tapes given to them were so badly recorded as to be impossible to transcribe accurately or at all. As Stockdale (2002) noted, noise can drown out softly spoken words and make transcription of speech difficult and tiring. He goes on to advise that audio quality also depends on using a suitable external microphone or microphones properly positioned near speakers in an environment with low levels of noise. I used a battery

driven digital recorder. This was because in some parts of Nigeria, there can be electricity disruptions. However, through my choice of fully charged battery powered recorder, I managed the interviews without fear of electrical disruptions or failure.

I also managed the interviews with the participants through the use of an interview guide. Some of the literature, such as that by Arthur and Nazroo (2003); and Willig (2013), suggests that semi-structured questions are a suitable approach for qualitative interviews. The semi-structured guide is attached as appendix 8. A semi-structured approach to data collection is closer to what Rubin and Rubin (2012) referred to as topical interviews. These could be focused on a particular event or process, and are concerned with what happened and why. As Rubin and Rubin (2012) advised, deciding how far the structure and subject coverage should be specified in advance in any particular study requires careful thought about the nature of data sought. For instance, they suggested that if a study needs to provide evidence of people's experiences of a phenomenon, then there are likely to be specific issues about which evaluative commentary is sought.

With this in mind, I had developed a preliminary semi structured interview guide in relation to the body of literature around schizophrenia and recovery. This semi-structured interview technique allowed me the opportunity to explore the participants' own views and experiences. It also allowed me the possibility of discovering the subjective meanings and interpretations that men gave to their health and illness experiences (Denzin, 2009).



Prior to utilising the interview guide, one option, I explored during pilots, was its effectiveness. Its utility was considered in terms of issues covered, interview session timeframe and recording equipment. I found that the questions or issues addressed appeared appropriate, as it did help elicit data on the men's experiences and aided exploration of meanings and concepts. However, I reasoned that some areas would benefit from rewording and restructuring and these changes were therefore made. Also, the timeframe of a sixty-minute interview was found to be sufficient for the purpose of the final study. This time duration, allowed adequate time to go through the questions and for suitable responses to be provided. The significance of the pilot study also added to idea that the use of audio recorder was important to ensure gathering information from the final interviews.

I felt that using the semi-structured guide, while it allowed me flexibility, also enabled me to focus the interview session. In this approach, although I had prepared an interview guide before the interviews, I had room to manoeuvre. I had room to explore in the sense that I did not have to rigidly adhere to the semi-structured guide. In contrast to the rigid nature of a standardised questionnaire, I was flexible in terms of the precise wording of questions and the order in which the questions were asked, which allowed the participants to tell their story in a way that best suited them whilst still providing the information required to address the research questions. As Arthur and Nazroo (2003) noted, while a structured interview can have a fixed set of questions, which does not permit one to divert, using a semi-structured guide allows flexibility in relation to the interviewer questioning.

However, there were occasions when participants in this study gave their discussions in a muddled way. On these occasions, when I felt that I was losing track of the interview direction,

and the interview guide then helped me to refocus the session. Whilst some of the male service users sometimes expressed their views in traditional language, the hospital staff seemed more conversant with English language. However, like some service users, there were instances, where health professionals repetitively focused on particular views. If I felt that participant was becoming too repetitive, I waited for a natural break in the flow of speech, turning to the questions on the interview guide as a refocus tool.

Because there was more probing, during the interviews, I realised that the use of a semi-structured approach afforded me the opportunity to continually mould the discussions. Probes such as, “what is an example of that?”, “why do you think that happened?” or “what were your thoughts at the time?” were used to encourage reflection about particular experiences and elicit further, often more in-depth information. As Olliffe and Mzoz (2006) suggest probes were particularly effective in this study because its usage encouraged participants to describe and detail their experiences, and enabled us to clarify what was being said.

Another important skill that I used to focus the interviews, was active listening. In some instances this involved clarifying questions, paraphrasing or summarising. It was also necessary to employ these interview skills, because as I pointed out some over-talkative participants did muddle up stories.

Having outlined the data collection methods used in this current study, it is now important to consider data analysis.

#### 4.3.5 Data analysis

This qualitative study utilised Braun and Clarke's (2006) thematic analysis as a methodological approach in the analysis of the text generated during the interview sessions.

By utilising this data analysis framework, I aimed to identify and examine the categories, concepts and themes which participants brought to light during interview discussions. The six-phase guide to performing thematic analysis in this analytical framework include: "familiarising yourself with the data", "generating initial codes" "searching for themes" "reviewing the themes" "defining and naming themes" "writing up." In this section, I use this six-phase guide as a convenient way of explaining the method of analysis used in this study.

**Phase 1: In the initial familiarisation with data phase,** I commenced transcription. I uploaded the audio recordings of interview discussions onto a transcription computer programme known as Express Scribe. I then began to listen to recorded discussions, using this transcription software in the conversion of human speech to a text transcript.

Difficulties were experienced transcribing the audio recordings of these interview discussions. Some of the participants spoke using colloquialisms and expressions in pidgin English, a traditional language. It was difficult to punctuate the transcripts as the nature of conversational interaction is such that sentences sometimes run on. Likewise, sometimes sentences are left incomplete and it can be hard to determine where one sentence ends and the next begins. This is partly what I meant earlier in this chapter, when I discussed managing the interviews, noting that some of the participants spoke in muddled way.

Punctuating the interviews in such a way as to retain the original sense of the discussions and make the transcripts readable was very challenging in these circumstances. This necessitated listening to the interviews several times in order to hear correctly and decipher the sense of what was being said. I found this very tiring. This is representative of what, Brown and Lloyd (2001) noted when they observed that an hour of recorded conversation may take three to five hours to transcribe and result in many pages of text for analysis.

Despite the demanding nature of the task, I kept at it because it was important that the transcripts retain the information from the verbal account, and in a way which is true to its original nature. Looking back, the time spent in transcription was valuable, as it helped me develop familiarity with the interviews and more understanding of the meanings of the data through having transcribed it.

**Phase 2 Generating initial codes.** The coding of the data involves fragmentation and categorisation of text so that I began to organise data into meaningful groups. Coding was aided through a computer software programme NVivo (Gibbs, 2002). As Bazeley and Jackson (2013) explain, data analysis with NVivo is very useful, as the application helps with the storage, systematic coding, and management of huge amounts of data generated by a qualitative study. The other reason I decided to use NVivo is because it is supported by my educational institution, so help in its application was readily available at the University.

When codes are applied and reapplied to qualitative data using this type of computer assisted program, I was codifying. This was a process that permitted me to segregate, group, regroup and relink data in order to consolidate meaning and explanation (Grbich, 2007). This is

representative of what Saldana (2013) means when he suggests that coding is a method that enables you to organize and group similarly coded data into categories or families.

This meant that I began by reading through the first male service user transcript, then working systematically through all the transcripts including the data from the health professionals interviewed in this study. As I read through the transcripts, I became aware of textual fragments that may be identified as a code. Such textual fragments may be a sentence or a paragraph. I demonstrate how I coded the text, using the following comment by Abia:

*In my own case, I can say that because of these kinds of behaviour that man is expected to be, it can caused me to have this thing that it is called schizophrenia. Because of this, you can talk to your wife and she can be able to help (Abia 29)*

I regarded this entire comment as a textual fragment because it encapsulates ideas about cause of schizophrenia and recovery. I coded the fragment as “cause of schizophrenia” because part of what this fragment does is to define Abia’s ideas about schizophrenia. In talking about this, Abia said “*kinds of behaviour that man is expected*” This suggested that there was a need for the code “masculine expectation” one level down from the main code “cause of schizophrenia”.

I also coded the fragment as “recovery” because it connected Abia as a man who can draw on resources. Within the code relationships, I coded it “gender negotiation” one level down from the main code “recovery” because with the phrase reference “*you can talk to your wife*” Abia was saying how he saw himself as someone who can negotiate masculine expectations and is thereby aided in his recovery.

**Phase 3-Searching for themes.** I started this phase after I had a long listing of different codes identified by reading through the transcripts.

This phase refocuses the analysis at the broader level of themes rather than codes. Braun and Clarke (2006) contend that a theme “represents some level of patterned response or meaning within the data” (p.82). This is representative of Boyatzis (1998) definition of a theme “as a pattern found in the information that at minimum describes and organises the possible observations or at the maximum interprets aspects of the phenomenon” (p.161)

As I continued to read the transcripts, I began to assemble all of the positions assumed by participants in their discussions of the issues. I gradually began to see that there were patterns to them and that some positions could fit together. Similarly, the analytic process involved a progression from semantic (more descriptive), where the data being organized into categories are further interpreted into latent (more analytical) themes. In essence, I further theorize the significance of the patterns and their broader meanings and implications, often in relation to previous literature.

Some initial codes became merged to form main themes, whereas others formed sub-themes. This may be representative of what Mason (2002) means, when she outlines the implications of a reflective approach, noting that a reflexive reading will locate you as part of the data you have generated. In essence, as I continued to read through each of the transcripts, I continued to enhance my understanding of the data. As Tuckett (2005) argued, this type of iterative engagement with the data may have enhanced this data analysis by sensitizing me to the subtler features of the transcripts and issues discussed during interview sessions. So with each reading and engagement with the data, I was cutting quotes, sections of text through transcripts, and

then arranging them systematically. I ended this phase with a collection of themes and sub-themes and all the extracts of data that have been coded in relation to them.

**Phase 4: Reviewing the themes.** During this phase, I was involved in refinement of themes. I was very mindful that data within themes should link together meaningfully. So I read all the collated extracts for each theme and considered whether they form a coherent pattern. In some instances, I found that data extracts within it simply did not fit there. Because of this, I reworked the theme. I did this mainly by finding a home for those extracts that did not currently link into an already existing theme.

The second approach to refinement of themes that I employed was to code any additional data within themes that had been missed in earlier coding stages. This was beneficial to me in two major respects. Firstly, it was possible for me to revisit the data. In so doing, secondly, I began to identify new themes or amend existing ones.

One issue that I experienced at this phase was the difficulty of knowing when to stop. I was continually, comparing and contrasting the different ways in which participants spoke about the issues during the interview sessions and was becoming enthusiastic. However, as Braun and Clarke (2006) advised, this process can continue *ad infinitum*, that is infinitely or endlessly. However, I had to stop when I realised not only clear and identifiable distinctions between themes, but also that data within themes linked well enough to be coherent to a reader.

**Phase 5: Defining and naming themes.** At this point, I was constructing a concise and informative name for each theme. This is what Boyatzis (1998) referred to as a “label... a definition of what the theme concerns” (p.30).

The question I constantly asked myself was - what story does this theme highlight? I also asked myself how this theme fitted into the overall story about the data. In other words, I was considering the essence of each theme and its place within the whole. So it was vital that I did not just paraphrase the content of the data extracts presented, but identified what was of interest about them and why. So, at the end of this phase, I was able to define the issue constituting each theme in one word or a short sentence. In doing so, I felt that it was important this definition convey to a reader a sense of what the theme was about. For example, as will be discussed in the analysis of participants talk about recovery, I identified themes such as “western medicine”, “traditional medicine” and “family support” which were associated with recovery. Within each of these themes, sub-themes (themes-within-a-theme) were further identified. However, let it be noted that these eventual final themes and sub-themes resulted from an iterative process of refinement of initial themes and sub-themes.

**Phase 6: producing the report.** Now I had a set of final themes and sub-themes, I had to consider how to present the results of the study credibly. In presenting a report on the findings of thematic analysis, I discuss each of the themes in turn, referring to examples from the data and using direct quotes to help illuminate them for readers. When views were not shared by these two groups of participants this was highlighted. As Braun and Clarke (2006) argue, the aim is to build a narrative that tells the reader how your findings have cast light upon the phenomenon or question under study.



#### 4.3.6 Demonstrating rigour

Lincoln and Guba (1985) asked, “How can an inquirer persuade his or her audiences that the research findings of an inquiry are worth paying attention to?” (p. 290). It is from this point of view that in their pioneering work, Lincoln and Guba (1985) suggested four criteria for demonstrating rigour in qualitative work as alternatives to those used in quantitative research:

The first criteria is credibility in place of validity, referring to the extent to which interpretations are compared. The second is transferability in place of generalizability: this is based on researchers’ ability to provide sufficient detail so that a reader can assess the extent to which the conclusions drawn in one setting might transfer to another. The third is trackable variance in place of reliability: the conventional notion of reliability in quantitative research assumes a high degree of stability in research settings, such that replication is a realistic possibility. However, qualitative research generally assumes that the real-world settings inevitably change and replication is thus unachievable. Lincoln and Guba (1985) therefore argue that instead qualitative researchers need to demonstrate that they have taken into account the inherent instability of the phenomenon. Confirmability in place of neutrality is the final criteria, where qualitative researchers present sufficient detail of the process of their data collection and analysis so that a reader can see how they might reasonably have reached the conclusions they did.

Halfway through the project, after I had interviewed the participants, I became aware of the enormity of qualitative research. I was laboriously wading through pages of typed transcript from the interviews and I remember suddenly feeling completely overwhelmed. The transcripts I was reading were full of ambiguities and contradictions. I realised, that the task of constructing meaning from other people’s talk is neither easy nor straightforward. This

revelation suggests that coming to what might be thought of as credible conclusions based on the issues that other people say or do was a major undertaking.

In these circumstances, it was necessary to adopt an explicit analytic method. As indicated, utilising Braun and Clarke's (2006) analytical framework was very significant to development of concepts and themes.

I also employed triangulation. Writing about quality in qualitative health research Mays and Pope (2006) suggest that triangulation allows the possibility that a problem may be seen from varied meanings, from different perspectives. That is, if themes are established on converging sources of data, then the process can be claimed as adding to the credibility of the study. In this regard, data sources of information that I used include the views of the men and their mental health practitioners. As Mason (2002) noted, seeking to corroborate one source with another or enhance the quality of the data through some form of triangulation is a technique of research to which many subscribe.

In addition, I lived and worked in Nigeria for one year during the course of data collection. This opened my eyes to ways of daily living of some Nigerian communities helping me understand the wider social context that formed the backdrop to the study. As Creswell (2014) suggests, spending time in the field can increase understandings of patterns of behaviours, language and actions of the communities under study.

It has been suggested that in a qualitative study, researchers can check that their conclusions are credible by checking with other studies. For instance, Tracy (2010), in writing about meaningful coherence, noted that another path toward achieving meaningful coherence is

ensuring that the study hangs together well. In this way, the reviewed literature helps situate the findings. The findings attend to the stated research questions and meaningfully interconnect with the literature and data presented. In contrast, incoherent studies may fail to link up with the prior scholarly literature used to justify the importance of the study.

From this point, I compared and contrasted findings of this study through reference to other studies. Where literature was available on specific issues under discussion, I have presented them alongside the findings from this research. In doing so, I hope that this research can be relevant through adding to current knowledge or increasing the confidence with which knowledge is regarded. In other words, I hope to contribute to our understanding of community life and help make visible what might be hidden or inappropriately ignored. In doing so, I hope my findings will contribute to understanding current perceptions and experiences of schizophrenia and emerging influences on men's recovery from the mental health problem. These findings could offer those involved in their care extended or alternative understandings, with implications for the recovery of men.

#### 4.3.7 Ethical considerations in health research

Ethical approval before commencement of data collection was obtained from Leeds Beckett University, Leeds, United Kingdom. These ethical permissions are included as appendix 8 and 9. Similarly, local ethical permissions from the Federal Psychiatric Hospital, Nigeria were granted, and are included as appendices 10 and 11.

In the literature, ethical issues arise in discussions about codes of professional conduct for researchers. Because of this, Beauchamp and Childress (2001) suggest four ethical principles which should guide and inform research that involves human participants. These principles include: autonomy, beneficence, non-maleficence, and confidentiality. Each of these relate to potential solutions to ensure the safeguarding of those involved in the research.

The principle of autonomy as an ethical code of best practice recognises the rights of the study participants to self-determination, informing potential participants so that they can make the decisions about whether or not to take part in the study. Therefore, it was important that both verbal and written information was made available to the study population. In a qualitative study of African American views about taking part in research, Freimuth et al. (2001) found that participants' willingness to participate in a study appeared to be enhanced by increased knowledge about the research and its purposes.

One implication of this for me was the need to follow an explicit recruitment process. The process of recruiting study participants was detailed in an earlier section. As demonstrated, participants were invited through an initial letter of invitation. Additional written information

in the form of participants' information sheets was then discussed with potential participants. These also include the provision of a reply slip in a pre-paid envelope for those participants wishing to take part in the study. As has been noted, having spoken to the male service users, under the care of the health professionals in this study, it became apparent how staff influence their experiences and therefore the study was expanded to look for views of the hospital staff, about supporting service users. As pointed out, there were no significant amendments to the recruitment information for hospital staff, with ethical approval for the addition of staff at the hospital as participants in the project granted in 2013 (see appendix 9).

Beauchamp and Childress (2001) referred to beneficence in research indicating that research should benefit the participants and society by making a useful contribution to human knowledge. Men's participation in understanding the causes and influences on recovery from mental illness can be beneficial to the men themselves, their families, to the practice of health practitioners and the decisions of policy makers. As pointed out, additional data collection with the addition of hospital staff as participants in the research offered a chance to health professionals in this study to have a say about supporting service users. Through learning more about hospital staff views on supporting service users, and encouraging self-reflection about their own experiences, had practice implications for the service user's recovery. This could be what Punch meant (2005) when he suggested that during the identification of the research questions, it is important to identify a problem that will benefit individuals being studied, as well as others.

There is a strong argument for suggesting that this research, which explores men's perspectives and experiences of schizophrenia and how they construe their recovery is within a principle of

beneficence. As Creswell (2014) argues, research questions arise from issues, difficulties and current practices in real-life situations. The benefit of this research to the participants and those involved in their care became clear when I asked myself, “What is the need for this study?” and/or “What problem influenced the need to undertake this study?” Having said that, it seemed from the ways in which the participants of this study discussed the issues brought up during the interviews that understanding the phenomenon was of great interest. Therefore, it seemed important to highlight the impact of gender on men’s perceptions and experiences of schizophrenia. In addition, it seemed relevant to highlight current influences on how the men are managing their recovery as this also has implications for health practitioner interventions.

Non-maleficence (Beauchamp and Childress, 2001). This principle has led to the development of a research code of ethics whose prime directive is that research should not be maleficent; that is, that research should not harm those who participate in a physical or a psychological way (Beauchamp and Childress, 2001). In evaluating the potential for this research to do harm to the participants, it should be noted that the study did not involve the testing of an intervention. Though this study does not use a methodology which calls for invasive procedures, there was still the possibility that those involved could be harmed psychologically as a result of their participation. For example, it was likely that during the interviews distressing issues might be revealed. Thus I was very careful to ensure that participants were not pressurised to answer questions which they felt uncomfortable with. Let it be noted that the interview guide used to manage the interview sessions had been vetted by ethical committees of both my educational institution and the psychiatric hospital. However, during the interviewing I was sensitive to overt and subtle signs of discomfort on the part of the participants. I hold an MSc in Mental Health and my experience of mental health work was very useful in this regard.

I also ensured that the interviews only took place in a safe environment. They took place within the psychiatric hospital and there were toilet facilities and refreshments available. In addition, the interview room was fitted with an alarm for use and interviews did not take place outside office opening hours thus ensuring that any potential harm to myself as the researcher was also minimized.

Other aspects of non-maleficence had to do with the potential dangers of breaches of confidentiality and the way in which I, as researcher, use information provided by the participants. Confidentiality is central to the trust between participants and the researcher. From an analysis of narrative data from 63 people with schizophrenia, Kaminsky, Roberts and Brody (2003) found that clarity about the use of personal information and confidentiality influenced willingness to participate in schizophrenia research. Because of this, I felt that it was my ethical duty to talk about confidentiality at the beginning of each interview. Furthermore, in promoting confidentiality, access to data was through a computer which was password protected for secure access. This was particularly important in a psychiatry research of this nature because information is so often collected about personal and highly sensitive issues. Thus, I have an ethical duty to ensure that being involved in research does not cause any harm of any of the people involved by breaching their confidentiality. Therefore, it was important that information relating to the participants' disclosure was protected as I explained.

Restricting access to data is perhaps the most important problem faced but it is not the only one. I minimised the possibility of linking data to actual participants through anonymised data. In the ensuing report, I protect the anonymity of participants by using pseudonyms. When I cite participants' comments, I use pseudonyms which have been anonymised. The pseudonyms were allocated through alphabetically ranking states in Nigeria.

Having outlined both the methodology and the methods used in this current study, it is then important to turn to a reflective account of the research process in relation to possible influences of my own background and experiences.

#### 4.4 Reflexivity in health research with Nigerian patients

In this section, I provide a reflexive account of the research experience within a research project that considered how male outpatients and their health practitioners' conceptualise schizophrenia and recovery from this in a community within northern Nigeria. Grbich (1999) suggests that reflexivity involves, "a process of self-awareness that should clarify how one's beliefs have been socially constructed and how these values are impacting on interaction and interpretation in research settings" (p. 65). I am a British-Nigerian. I was born and grew up in northern Nigeria, the study area. I attended primary school in the same area. Several experiences have stimulated my interest in research focussing on men's recovery from mental health difficulties. As a Health Worker, I have been aware of the effects of mental health problems and came to recognise the experiences of a group of service users' in recovery. The fact that I might be able to give them a voice to express their views and experiences through my research attracted me to this topic area. This may also have practice implications, as views expressed by services users can provide insights highly relevant for the development of professional practice. As Holloway and Wheeler (2013) argue, emphasis on qualitative research in nursing and healthcare may be best placed on topic areas that offer some specific hope for health professionals to consider how men understand their health. Similarly, Creswell (2014) points out that it is through choice of an appropriate topic area that health research may facilitate patient-centred encounters and offer specific hope for developing insights and deepening understanding of phenomenon under study.



In the early 2005, I commenced a Master of Science (MSc) study in Mental Health at the Leeds Beckett University, United Kingdom. During this course, I began to explore some of the core concepts around onset of mental health problems and recovery from the condition. Through examining the existing literature, I noted there were concerns regarding African men's significantly increased risk to psychotic conditions (Fearon et al. 2006; Kirkbride et al. 2012). The explanations for this supposed greater risk vary in the United Kingdom (Robinson, Keating and Robertson, 2011). It is a combination of these issues that alerted me to the need to focus my MSc study on African men. On reflection, it seemed there were gaps in the evidence base of that research, particularly it appeared that there was limited exploration of gender. Therefore, the knowledge I have gained from my previous study has inspired a desire to come to a more in-depth understanding of recovery. That qualitative research, undertaken in the north of England, explored the recovery from psychosis of African men attending psychiatric clinics within a National Health Service (NHS) facility. Although, the focus of that study was African male services users' recovery, it was within a western society's framework.

As I have pointed out, the methodological orientation of this study is exploring experiential accounts of men recovering from mental health difficulties. It was important, therefore, for me within the research project to identify participants that possess related features, to provide insights into their health and well-being. It is against this backdrop, which as the idea for this project was forming, that the choice of the place I was born (and where I had some familiarity), was my first option for my research investigations. Growing up in the study area (and/or indeed as a Nigerian) is of key significance to my understanding of the social life within the research setting. This experience of growing up as a Nigerian man helped me with understanding and evaluating the social relations of the men in my study. In particular, it helped me understand the socially embedded nature of expected standards, or societal norms, of male behaviour,

which I have already been exposed to related to my own male identity. Indeed, I recognised experienced in the interviews some of the gender positions reported within the literature, and how some of these related to my own ways of doing my male identity in practice, including conversations where I demonstrated or reflected the hegemonic norms common to the locality. Whilst such conversations could be seen as ways of establishing a rapport, as Robertson (2006) suggests, it also represents a combination of my wishing to be sensitive but also a fear of how I might be perceived by the men. This position, this fear of how I might be perceived is further highlighted by the fact that I specifically mention my male identity as heterosexual, and/or as a hegemonic man in some of the interviews. This strategy, I have since discovered can often be utilised by male researchers to reassure curious participants concerning their identity (Olliffe and Mroz 2005).

Reflecting on the impact of my role, I felt that my position as a British Citizen researching in Nigeria, had a positive impact which aided trust among the study participants. Reflecting on the impact of researcher identity and power dynamic within research interview, Bourke (2014) also identified the importance of trust and as Kurylo (2016) suggests the power relation between the interviewer and the interviewee, is such that without trust interviewees can withhold information, thereby affecting the data collected. Before, the interviews, I felt nervous about discussions on such a sensitive topic and about my ability to obtain high quality data from study participants. To help address this, at the initial phase of the interview, I explained to men, that I was a student from the United Kingdom. Among the men interviewed and their health professionals, the United Kingdom is held in high esteem and associated with very high standards of conduct and work. Therefore, for many participants this approach helped me develop what felt like a genuine and mutual rapport. The pleasure my participants and I experienced through the rapport developed in these interviews definitely contributed positively

to the quality of data collected. In an analysis of researcher identity, and its impact on the interview situations in Kerstetter's (2012) study, several researchers suggest that a positive view of their identity aided constructive engagement with the interviewees. Also, Anyan (2013) analyses the power relation between the interviewer and the interviewee and suggests that the support of the interviewee was related to a positive perception of researcher identity. As evidenced by the wealth of data that was obtained during interviews with the participants in my study, data collection seemed largely dependent on cultivating positive relationships and building trust. This comfort was created through an interaction, where my British identity was highly valued, but there were times where I felt it may have also been a problem. For example, there were instances when participants related experiences about aspects of their recovery and asked me for advice. As a researcher, these moments placed me in a difficult position and I realised I had to be very careful about what I said during interviews to ensure I never gave advice about their condition or their recovery. On the one hand, I wanted to appear helpful and responsive but on the other hand I did not want to give advice, which I felt I was not qualified to give and could be potentially harmful. I handled these situations by explaining that the interview was not really set up as a forum for advice, but that help could be sought from their health worker.

## 4.5 Summary

In this chapter, I have highlighted the methodology of the study, discussing the centrality of social construction perspectives in health research, and how these underpins the theoretical foundations for conducting this qualitative research. Taking a social constructivist stance informed the research design and influenced the choice of methods adopted in this study. It was therefore appropriate, through this emphasis on the significance of understanding meanings, for me to purposively sample male services users with experiences of schizophrenia.

With the inclusion of staff at the hospital as participants, I was able to collect additional data on their experience of supporting the men, which provided further insights in understanding schizophrenia and men's experiences of recovery from this mental health condition within a community in northern Nigeria. I outlined how I maintained rigour in the interpretations of the data collected through interviewing, using an explicit analytical technique for data analysis, triangulating staff data with service users views, and by making links to prior literature. I discussed the ethical considerations that enabled me ensure the safeguarding of those involved in this study and concluded the chapter with a personal reflection, which highlights the influences on me that shaped the research process.

Having outlined this study's methodology and methods, the three following findings chapters are based around understanding gender expectations and its impact, the religious-spiritual beliefs and biological causes of schizophrenia, and exploring recovery as multifactorial.

## CHAPTER FIVE

“As a man, I am supposed to be the head of my family, so I have to provide for my wife and children, even though this put pressure on me to do as expected of a man”: UNDERSTANDING GENDER EXPECTATIONS AND THEIR IMPACT.

### 5.1 Introduction

This chapter discusses the men’s perceptions and experiences of schizophrenia that emerged from the data in relation to the theme of gender. In particular, this chapter provides insights into the meanings of gender, including traditional stereotypical views about gender being fixed through to non-traditional flexibility in gender relations. The chapter provides insights into traditional notions of masculine expectations relating to male as household head, and linking this to schizophrenia. This chapter finishes by drawing on gender flexibility and relating this to men’s recovery.

### 5.2 Definitions of gender

The findings of this study demonstrated that many of the participants understood gender as being associated with tasks, roles or behaviour. Linked to this, two-subthemes emerged in their definitions and these were traditional views of fixed gender and non-traditional gender flexibility. The comments below reflect many of the participants’ views evident in this study:

*Gender role means that there are some kind of behaviour that people are expected to do. In this our society, there are certain behaviour that one is expected. We can call it also that there are tasks or type of behaviour that is expected of you (Osun 40).*

*When we talk about gender, to me it is clear that we are talking about what the male and female in the house can do. In the household, that is in every family house, where the family live together, you find that there are certain types of tasks that the society expect from each other. So every household and the family members that help the house can begin to divide these tasks, where you find that what is expected of the male can be different from the female (Bauchi 27)*

This differentiation in how roles within the house into those performed by men and women was evident in other men in the study.

As Akwa Ibom says:

*This idea of the sort of behaviour that you are expected to do is based on your sex. You know man or woman are different from each other. So as a female, you are expected to do certain tasks. And as a man you are expected to other different things. So, I would say I understand gender roles to be the sort of behaviours that are expected based on your sex (Akwa Ibom 30).*

Similarly, Baylesa explains:

*A man is different from a woman. A man is a man and a woman is woman. So both of these people are different. I don't think that both of them are the same kind of people. Even when they were born, the man was born a man, so that biologically we can say that the man is not the same as the woman. If both of them are different biologically, then may be what a man can do is different, from what a woman can do. So that is the reason their roles are different. Because in the society we know that man or woman is different, so too the roles for each of them is different (Baylesa 34).*

The understanding of gender in this study, reflects Ayenibiowo et al's. (2012) comment that gender roles represent societies "expectations regarding the proper behaviour, attitudes, and activities of males and females." (pp.4770). Thus, traditionally, women and men are understood to differ in their expected gender behaviour (Connell, 2012; Oakley, 2015) with the idea that gendered expectations are fixed (Risman and Davis, 2013; Wood and Eagly, 2012).

This view of gender was not limited to the men in this current study, a similar understanding of gender was reflected by many of the health professionals interviewed.

*Gender is about family household relations. In every household, our society expects the family members that are expected to meet the family needs to relate. It is because of this you find within family members in the house there is an allocation of tasks in the household. This activities regarding what the female or male are expected to do is what is referred to as gender behaviour, and as I understand it is different role for a man and another for woman (Health professional, Abuja 40-44)*

### 5.2.1 Gender as traditionally fixed

One way in which this notion of fixed gender was practised within families, was in recognising that the man was conceived as the financial provider. In contrast, the woman was expected to focus on domestic issues such as cooking. Lagos describes this:

*To me, it is like the men have to bring money, while the women have to take care of the home like cooking. It is the men who are expected to bring the money to the woman, so that the woman can begin to take care of the house. When the man goes out to get the money, then the wife can stay at home to take care of the children. So in a way, men are the people to provide for the family (Lagos 22).*

It is from these and similar accounts, that the gender perception for some participants' centring on notions of man as the family provider resonates.

In addition, the data suggests that religion was a significant influence in perpetuating a fixed gender role view. As Kano explains:

*Even according to what is in the Bible, man is the provider. The Bible said that man should be the head of the family. You know in the Bible, God created Adam first. And Adam is a man. So God created a man first, so that he can be able to provide for the family. When, he then created Eve, God said that Adam the man, should help Eve. That is what is according to the Bible, and that is what is happening in our society (Kano 39).*

With regards to religious influence, Katsina also asserts:

*If we are to look at it from what is in the in Koran, then we can be able to understand that man is the one that is supposed to provide for the family. In the Koran, we can see that it is up to the man to provide for the family. When you take the Koran, you will find that is what is said there. (Katsina 27).*

From the comments above, about religious texts contained in the Bible and the Koran, it appears there is a recognition of the appointed guardianship and headship of men. This is of particular significance, because Christianity and Islam are the dominant religions practised among the men in this locality. As, such religion has a prime influence in the life of these men. Read (2003) conducted a study of women participating in both the Christian and Muslim faith which supports this notion by suggesting that women with strong religious beliefs have more traditional attitudes towards gender expectations than those with weaker religious ties.

Sokoto, one health practitioner concurs with this view:

*You will find that most of these men, believe in the Bible and Koran. Some of them will tell you that this is what the Bible say and this is what the Koran say. If it is something that is in the Bible or Koran, then it must be the truth. This truth that is within this Bible and Koran that they are always reading accordingly becomes their guiding principle. Like for some of them, they will say that the Bible said you must do this and the Koran support as well that you must do that same thing. (Health professional, Sokoto 40-44).*

Similar discussions were made by the participants about the family as a socialising influence.

In this context, it seems that both boys and girls are influenced by the behaviour of parental figures. This is exemplified by Imo who describes the family influence:

*You are born into a family. So you are not alone. You have your parents who will teach you the proper thing to do. When you are going wrong, they can remind you that it is not the proper thing for you to do. As they are your family, they would not let you to go astray. If you go astray, it is not good for them in the society. Then it is important for them to teach you the right time, which you can follow (Imo 28).*

This is representative of Masciadrelli, Pleck and Stueve (2006) findings in the United States, where the possible routes through which gender learning took place, included the influence of fathers as role models. This issue has also emerged in other Nigerian studies, where it was suggested that father role models demonstrate normative gender expectations by their behaviour in the home and community (Odimegwu and Okemgbo, 2008; Olawoye, et al., 2004).

The participants views suggests that traditional gender expectations being fixed are better known.

As Ebonyi mentions:

*It is good that man and women know what their roles should be. This is advantageous for everyone, because the man understand what he is expected to do and the woman understand what she is expected to do. They know what to do as these roles are clearly defined between the man and the women in the family (Ebonyi 40).*



As a result there appears to be a suggestion of less anxiety in the household, around how these expectations are negotiated or about conformity with specified gender expectations in the household, when these are clearly demonstrated and known. This view is echoed by Delta:

*When the man knows that he is expected to provide for the family, then there is no problem in the family. He knows that his role is to provide for the family, so that is what he does for the family. But if he does not know that he is supposed to do that then it could be a problem for the family (Delta 37).*

This finding is strongly supported by the literature which has noted a strong negative attitude towards men taking on more tasks in the sphere of domestic work. As Morrell and Ouzgane, (2005) pointed out traditionally, fulfilling the requirements of the male role as provider is characterised as an achievement. However, men are unlikely to participate in domestic work, as such tasks are considered to be the exclusive domain of women.

While the earlier discussion relates to positive comments about fixed gender expectations, there are differences in opinion to this view. In contrast, some participants pointed out that traditionally fixed gender roles were linked to a negative effect on men's health. In particular, many of the concerns talked about by the men were associated with the burden of traditional views of gender, which ascribe family headship to men.

Kogi, one of the men, illustrates the views of many participants and explains:

*The things that resulted into my problem are triggered by these burden. I am the only son of my parent. When you are the only son of the family, it means that responsibilities for everything falls onto you. In the Nigerian context, you know that means a lot of things that you are expected to do (Kogi 31).*

As Abuja, one of the health practitioners concurs:

*I think we are beginning to see many examples of stress caused mental illness. Because they present to hospital highly restless and when you try to find out from them about what is happening, you will see that is due to the stress from not knowing how to have money to meet family responsibilities (Health professional, Abuja 40-44).*

### 5.2.2 Non-traditional gender flexibility

In contrast to the traditional fixed gendered expectations, data from this study also indicate that gender, rather than being a constant concept, might be an evolving phenomenon.

As Adamawa says:

*I will say that my role as a man is no longer fixed, because you see these roles are not a static concept but appear to be something which is socially changing all of the time (Adamawa 30).*

Such information relating to flexibility in gender roles can be found in Kwara's explanation:

*Before you are expected to one thing as you are a man, but nowadays that is changing. In this our society most of the roles are changing. Nowadays it is like what a man can do, a woman can do too. So everything is more flexible these days. Previously when you look at it, you can say it is one thing for the man to do for his family, and it is another thing for the woman to do. Things are changing and these roles are changing in the house as well (Kwara 42).*

This implies as Connell (2005) suggests that gender rather than being fixed can transform.

Therefore, for some of these men household expectations are not rigidly assigned or traditional fixed.

As Niger further elucidates:

*Right from the Holy Book, Adam was in control, before the wife ate the forbidden fruit and that is how the problem started. I believe that man should be the head of the family because that is how God wants it. It is true that the man should be head in the family because that is how our God wants it. If we are to go along spiritual line, that is how God wants it, but in the world today, they have turned things upside down. However, society is changing and wife can care for the family in the same way as husband so I think it is not wrong for either the husband or wife to care for the family (Niger 38).*

One way in which flexible gender was demonstrated, was in the area of sharing responsibility, which subsequently lead to a transformation in traditional masculine expectations. For example, data from the study highlights how a poor economic situation was a significant influence in the shift from traditional views to flexibility in the gender division of labour. Edo, highlights the significance of the current economic situation within Nigeria:

*The economic situation in the country is hard. When economic situation is difficult then it is very difficult for every family. When it is not good for the country, then it is going to be difficult for the man and his family as well. Because when it is good for the country, maybe you can have more things that can come your way to help the family (Edo 45).*

Bauchi, realises how changes are necessary in light of this situation:

*In these difficult situations you would have to find new ways to cope in the family. When the economic is bad you have to cut your coat according to your size. If you do not cut your coat according to your size, it will not be possible for you to survive. So you begin to think which kind of changes that you can make the kind of roles that you are playing in the family (Bauchi 27).*

As Eboiyehi et al. (2016) argued that under difficult economic situations, the concept of the male breadwinner whose masculinity hinges on his sole ability to financially provide for his family is challenged. One implication of this was the weakening of boundaries around gendered expectations. In essence, the need for survival became the most important issue, leading to leading to a change in women's role in maintaining the family's financial wellbeing.

With regard to the influence of education on gender redefinition within the Nigerian context, Egbucha (2006); Okonkwo (2009); and Omadjohwoefe (2011) had explained that amongst some traditional communities, the participation in certain educational courses might have been along gendered lines. That is, females participating in cookery courses, and males focusing on medicine and engineering. However, data from this study suggests that current thinking about participation in education appears to be also undergoing change, as it appears women are engaging in educational studies previously recognized as the exclusive preserve of men. As Ogun asserts:

*These days, you see that education is changing things. This is because female are going into new education. Before you can say that the type of education that the women has to study, is to help with her role in taking care of home. Especially, you see that they are encouraged to learn of cooking. So they go to learn Cookery courses for example. But these days, some of them are learning about engineering or medicine, which was like what the men were studying (Ogun 55).*

Consequently, this new development seems to have facilitated a new status for women based on their new found knowledge and skills. It is in recognition of this, that the findings of this study indicate that education is a contributing factor in women getting better jobs. Moreover, as a result of educational attainment, women are more able to assume roles outside the domestic domain. As Ondo states:

*It is when my wife completed the course, that she was doing she got a job as an engineer. Before everybody was thinking what is she going to do. But after finishing the course, it made it possible to have a job. That time the company was looking for someone who is qualified, and as she was qualified, it was possible to get the job. So education is important, as it can help to job (Ondo 36).*

This argument strengthens the point indicated that Christianity and education as aspects of colonialism contribute to the gender discourse in Africa (Frankema, 2012; Nunn, 2014; Woodberry, 2004). Some important gains have therefore been made in recent years through education which have allowed women to become more involved in paid work than was previously the case. As Nwosu (2012) comments there are changing times in Nigeria today and these have opened up more opportunities for the advancement of women. Yet this also has an influence on the reconstruction and liberalisation of traditional gendered expectations of men.

Given the foregoing discussion, it appears that there is a multiplicity of views about gender, while some believe them to be fixed others seem to recognise its dynamic nature. This has implications for men's recovery from mental health condition which will be discussed.

### 5.3 Male head of the household model and links to schizophrenia

The establishment of a household- by getting married, becoming a husband and a father of children- facilitates a new status for a man as the head of this household (Hendricks, Swartz and Bhana, 2010; Izugbara, Kabiru and Ezech, 2011; Snow, Winter and Harlow, 2013). This view was common in the current study and had several aspects to it discussed within this section.

#### 5.3.1 Marriage expectations

The interviews with the participants' indicated that men were under pressure to marry almost the moment they were perceived to be adults. As Kaduna says marriage at a certain age is a societal expectation:

*You see my brother in this our country Nigeria, one thing is that the society believes, I should not stay on my own for one thing, or remain single for too long. Everybody is saying that I must get married to a girl. So now what a lot of people are saying right now is that I should be married by now. By now I should married, by now I should be married (Kaduna 30).*

This notion also came up in previous literature (Appleton, et al., 2012; Olawoye, et al., 2004; Temale, 2011) which argued that adult men are not only supposed to marry, but also to provide for their wife and children. This is particularly the case across Nigerian communities where an adult male who has reached marriageable age of between 18 and 20 years is expected to marry (Olawoye et al. 2004).

There could be many explanations for this type of marriage expectations. As previously highlighted, this traditional view may be due to the influence of religious beliefs, such as adherence to what has been scripted in the Bible or the Koran. However, many of the participants further argued that a man commanded respect from the community when he gets married and establishes his own household. The participants further indicated that marriage was important because they wanted to have children and form a family.

These sentiments are reflected in the comments by Jigawa and Borno:

*When you get married you are expected to form a family. It is necessary that you form a family. So when you take in a wife, you know that you are expected to have form children. So the both of you begin to form children together. That is what the society expects form you as a man. And that is what makes you to go into marriage. So that you can have children and form a family (Jigawa 30).*

*Man's role in the family is a very vital role because when a single man marries a woman, he becomes the head of the family. The woman will be under him, if there is no money, the wife will ask him to bring money to take care of the children (Borno 28).*

Echoing this traditional view, Benue demonstrates this family headship concept, and how certain family responsibilities rested with him:

*That is how I can describe it. Now if to say I am a woman like now my sister, I always tell them to stay at home. They should not go out to sell things or to engage in any commercial activities. I ask them to stay indoors. I take responsibility that I would help them. I would provide whatever they need (Benue 30).*

The family responsibilities talked about are numerous. The impacts of these will be discussed later, however, these can include responsibilities for sheltering, educating, feeding, clothing, and paying the medical bills of this family unit. For example, Delta, had to provide family accommodation:

*But it is our tradition in Nigeria, you know that all of us expect the wife and the children and family as living in the man's house (Delta 37).*

In the case of Ondo, this meant he had to pay children's school fees:

*And the schooling of the children the man is responsible for paying their school fees. As a man he is definitely responsible for his children fees. So when he is paying their school fees they can be able to attend school properly. The man has children and they need to go to school, so he is the one that is responsible to pay their school fees (Ondo 36).*

Similarly, Anambra, indicates that this included responsibility for medical bills:

*If my children are sick, I cater for my children when they are sick. If my children are sick, I use to carry them to hospital and the doctor will tell me and write down medicine for me and I go and buy for my children (Anambra 37).*

A similar position is put forward in other research (Odimegwu and Okemgbo, 2008; Sternberg, White and Hubley, 2007; Wilson, 2003) where many participants' felt that being a husband and provider were important societal expectations of being a man. For example, Odimegwu and Okemgbo's (2008) study explored perceptions of being a man among Igbo living in Imo, Nigeria. Here there was the notion that men's main responsibilities as a provider included provision of a house for the family to live, food and payment of school fees for children and family medical bills.

Despite the suggestion among study participants that being a husband and providing for the family are expectations for a man, there have been difficulties identified in meeting this expectation.

Kwara's comment below reflects many such concerns expressed by study participants:

*There are so many responsibilities in taking care of the family. But sometimes you know that we, as a man cannot be able to meet up with this responsibility. I think that this pressure to find a solution for the children school fees can cause him stress. Because he will always be thinking how he is going to take care of the children. You will be thinking, thinking, because the responsibilities needs to be fulfilled and it is not always easy for the man (Kwara 42).*

Therefore, it seems, there are some dangers associated with such marital demands and this then raises issues about how fulfilment of these gendered expectations can have a stressful effect on some men. This is representative of what Pleck (1995) means when he suggests a gender role strain paradigm, where men could experience "dysfunction strain", when fulfilment of societal gender expectations can be difficult. One feature of this concern is that these gendered expectations could put pressure on the man to do everything to make sure his wife and children are provided for. Another feature is that some of the men could be experiencing stress by worrying about how to accomplish their responsibilities. I discuss this further in a later section of the chapter, which focuses on the man as worker.

As indicated at the start of this chapter, gender flexibility in household expectations, in contrast to traditional fixed roles can afford some of these men the opportunity for their partners to assist. However, this can be problematic, in the sense that such a shift in responsibilities can result in other problem. This other problem is what Pleck (1995) referred to as “discrepancy strain” where men’s inability to fulfil family responsibilities was associated with shame and ridicule.

As Delta explains:

*If your wife begin to do what you are supposed to do as a man. It might be difficult for you, as a man. Sometimes, the children might not respect you again. You might lose respect from the children, because it what you are supposed to do as a man, and the woman is doing it. If the children, come to you for something and you cannot do it, they will respect the person that helps them more. So that is the problem, when the lady starts to contribute more than the man, because he can lose respect (Delta 37).*

In other words, it appears that for some of these men, there are still expectations to meet traditional views on gender, such that flexibility in household relations might conflict with this expectation, as it is indicative of the man’s inability to fulfil his role as head of the household. As Pleck (1995) suggests, this inability can have “negative consequences for self-esteem and psychological well-being because of the negative social feedback as well as internalised negative self-judgements” (p.13). For example, among households in the Yoruba regions of south-west Nigeria, Cornwall (2003) documented accounts of women belittling their husbands when they were unable to provide financially for the family. In such households, relationships between couples become stressed.

Katsina, seems particularly concerned about his problem.

*It is not an easy situation, as you are expected to provide for the family but you cannot for now. Sometimes there are problems in the house. This can lead to quarrels. Every day the man is quarrelling with the wife, and there is tension. There is this tension because the wife is looking down on the husband as he is not able to provide for the house (Katsina 27).*

Another stress for the men was in the paying of the bride-price, which is part of traditional marriage. As Bayelsa notes:



*When you go to the village to take a girl to marry, then you have to talk to the parents. The parents of the girl will tell you about the bride price. You have to give this bride price to the parents of the family before the girl can be allowed to go with you for the ceremony to become your wife (Bayelsa 34).*

This is affirmed by the comments in the studies by Iroegbu (2007); Ogbeide (2011); and Onyima (2015) who suggested that, in many communities in Nigeria, the bride-price is commonplace. While it is possible that the amount can be negotiated, it is unlikely to be waived and this then raises concerns about being able to fulfil the marriage expectations for some of these men. Problematically, it seems that parents calculate the worth of their daughters in monetary terms, such that higher levels of educational attainment for the bride can lead to a larger bride price.

Imo talks about this type of bride price associated with the marriage dilemma:

*The parents say that I must bring this money, because they too have spent a lot of money to train their daughter in education. The money you give for the person that have gone to university is different from the one that you have to give for someone that has not. Sometimes, you might not have this kind of money and it will be very difficult for you to give the parents the money (Imo 28).*

Related to the bride price payment is another cost, relating to the marriage ceremony itself. Often, after the customary arrangement where the payment of bride price is completed, the marriage is institutionalised by a religious or civil ceremony and the cost might be problematic for some of the men in this study.

As Nasarawa says:

*The ceremony is expensive. We have to buy food, buy goats, buy cows, buy drinks, pay hotel for my wife people, rent hall for ceremony. My brother it is too expensive. This cost is too much for me and I don't have the money for it (Nasarawa 27).*

Others echoed similar feelings. Mudiare (2013) found that among the Hausa population in northern Nigeria, for example, the celebration goes on for up to seven days with different activities for each day, before the couple is finally left alone.

Considered together, these results suggest that the costs of formalising marriage, exemplified by both bride-price and the marriage ceremony can be a source of concern.

*A man is expected to get married, but it not easy to get married. Marriage is not easy. It is not an easy thing to do for the man because of what is involved before you can say that you are married to someone. The marriage costs are too much. You have to pay a bride price. This is the money that the man should pay to the family of the lady. You also have to make arrangements for the ceremony and all of these costs money (Niger 38).*

*I had to borrow money. It was the money that I borrowed that helped to complete my marriage. Marriage is an important thing for us to do, so sometimes you can borrow. If you have some of your brothers and sisters that can help, then you can borrow from your family or friends. But problem is that after the marriage you be worrying how you are going to repay (Kwara 42).*

It is in light of these difficulties with fulfilling marital expectations that an option might be to violate the marriage concept. However, the problem is that deviation from marriage often leads to ridicule. As Enugu and Edo says:

*I was forty-two years and never married. I had been alone all these years and because I was alone I was not regarded as a man. Every day the people in the village will be mocking me when I am passing on the street. Some of them say, look at that man he does not even have a wife at his age, so he cannot be our chief in this village. Even some of my brothers say that because I am not married, they cannot come to my house because do not know if they will have food to eat as no woman to cook (Enugu 42).*

*No one will respect me because I am not married. The moment that you are not married nobody in this our society will respect you. A married man is a responsible man. So if you are unmarried than you are irresponsible (Edo 45).*

There is a concurrence with this type of concern in the literature. Underlying, gender role conflict theory O'Neil (2008) refers to such "devaluations" as negative critiques of self or others when deviating from, or violating norms of masculinity, resulting in the lessening of personal status. Similarly, Uchendu (2007) also documented how unmarried men face mockery with, a single male been referred to as a "male-woman", a pejorative term in which the unmarried male might be suspected of being impotent.

Taken together, it appears that there is a multiplicity of views about family headship, which is often exemplified by marriage expectations. However, an implication for the pressure of living up to this is its triggering effect for the onset of mental illness.

As, Bauchi says:

*The moment that I was 25 years my parents sent me to go and make an engagement to a girl in our village. I am on the age of marriage. But I do not have much money. I do not have much money at the time to do the engagement to the girl that my parents wanted me to do the girl who they said is a nice girl and that I can get married to in our village because of this, I was always thinking, thinking, and thinking. It now leads to mental illness. It now leads to mental irritation and mental illness. Like someone having madness. Because of this they brought me to this psychiatric hospital (Bauchi 27).*

Yola and Dutse, health practitioners concurs and go on to support the men's views:

*There is this big expectation to get married...it is marriage, marriage and marriage. Therefore there is the expectations of the society for the male to arrange everything for the marriage. The pressure is heavy on one particularly as a man is expected to be the one to meet up the demands of the marriage. He is expected to get married, so he has to go about finding how to achieve this and often he soon realises that this requires money (Health professional, Yola 25-29).*

*The man would be worried and thinking, how he is going to take care of the family. Then through thinking and worry, it will have some effects on him and it will make the sickness to be worse, because he is thinking of many things on how to take care of the family, when the money is not too much. He is not getting any money that the government. And that will lead to thinking and more problems can develop from that including mental illness (Health professional, Dutse 30-34)*

The societal notion of being a man, reflects expectations to be in marriage, however there are other expectations to this, and this is discussed next.

### 5.3.2 Man as worker

Alongside marriage expectations, men were expected to find employment or start up a business to raise the money required to meet the needs of the family (Ratele et al. 2010).

*Having a job is very important in this our society. You know that in this our society there is nowhere that you can get money from. There is no body that can give you any money. It is only from your job that you can get money from. So it is important to get a job. And when you get the job, you can be able to feel that you are a man. Because this kind of job that you get, can help you with money (Kebbi 24).*

*As a man, everybody encourage you to have a job. Because when you have job you can be able to be responsible for your family help. With the money that you are getting from the job you can perform your responsibilities as a man (Lagos 22).*

Therefore, work is not only a measure of masculinity in itself but is also a means of fulfilling other measures of being a man such as being the breadwinner and financial head of the household (Barker and Ricardo, 2005; Lindsay, 2007; Ratele, 2008).

*When you have job or you have your own business then you can be able to provide the house for the children to live inside. Your children and wife can have a place to live as their home. Everybody needs a place to put their head inside and call home. And it is when you have the job, that you will be able to do this because you are head of the house (Adamawa 30).*

However, data in this study also countered positive views of man as a worker, and, instead, delineated specific concerns, about its links to the men's health concerns.

*I can say in my own case that there are some risks to this kind of work that men has to do. I am not saying that it is always bad to do work. It is not a bad thing. The problem is that you can experience some problems from this can of work. When you have this kind of job, it is good but you are bound to have some kind of problems. This kind of problems then might disturb you (Katsina 27).*

Abia, another of the men reports that:

*My family encourage me to work and bring money to them and marry with my own money. So that if I work and marry. Then I will be happy to take care of the family. To help my mother and to feed us. To train my younger ones. As a man you get challenges. And that is when challenges come to me (Abia 29).*

There is also acknowledgment of the difficulties and lengths that some of the men could be going to in order to meet gender expectations. Benue talked about this type of fulfilment hazard. He said that he had to go to work to take care of his family, even though it was perceived to be detrimental to his health:

*I take responsibility that I would help them. I would provide whatever they need. So that makes me to always go out and work that is the reason, as a man I think it affects me negatively. Because if to say I am a woman I could have stayed at home. I know if to say I am a woman, my brother will not even ask me to go out I will stay at home, I would not work. Being a man it affects my health. It really contributes to my illness (Benue 30).*

As Odimegwu and Adedini (2013) show, in a study which explored masculinity among the Igbo population of south-east Nigeria, having a job means positive social recognition and approval. Often, family and community are proud of an employed man. However, this quest to sustain family headship can lead to difficult situations whereby some of the men might engage in activities which could be detrimental to their health.

As exemplified in Ebonyi's comments about extreme efforts or over-working:

*As a man the society expects that you should be working. By working that is you should have something to do. It is very important that you have something to do, because that is when the village people will recognise that you are a man. And that is the problem, because I have to prove that I am a man, normally, I have to go to work. The other day, I had to be off work, but because as a man you need to be working hard, I still went to work. So you see, as a man sometimes, so of what they want us to do in relation to the job makes it difficult for us (Ebonyi 40).*

Adamawa also describes his difficulties with the gender expectations of being a worker:

*I am a business man, I always going to my shop. So I normally wake up early. When I wake up early, I will not go back to bed. Every day, I have to wake up early. That is what you have to do when you have all these responsibilities, because you need to wake up early to go to work. And when I go to my shop, I would not come back until after midnight. Even, if I am at shop and these symptoms come, I will still remain at work and this is stressing me up (Adamawa 30).*

Underlying this, is a concern that for some of these men recovering from schizophrenia might be made difficult by having to work laboriously over very long hours. This has implications for recovery, as this could involve or be characterised by excessive detrimental efforts.

Kogi and Nasarawa cited sleep deprivation as they wrestled with the idea of how to travel to their worksites:

*I am not sleeping enough. When a man has these kind of responsibilities and need to go to work it can affect him. Because you cannot sleep. You cannot sleep because you need to wake up to travel to work. The problem is that I live in a different place from my work place and it is far to travel to this work place. Every day I need to get up around say one in the morning, to travel to work. So travelling to work is affecting my sleep and making me not to sleep well (Kogi 31).*

*I have to get up in the morning to catch my bus to go to work. If I was living in the same place that I just got this job, then it could have been better. But I live in this other place. When you go to bed to sleep before you know it is the morning. That is why I say that I am not getting enough sleep (Nasarawa, 27).*

However, there was also a concern that fulfilling family tasks, could also be compounded by unemployment.

*There are no job for us. Everywhere, that you go there are no vacancies. So where are you going to get a job, when there are no vacancies for you to apply for a job. If there are no vacancies that means that there are no jobs. So it is a difficult time for all of us (Lafia 32).*

As Ammani (2012); Ogbonna (2012); and Owoye and Onafowora (2009) observed the adoption in the 1980 of the International Monetary Fund's Structural Adjustment Program (SAP), brought about a re-structuring of the Nigerian economy. This led to the loss of jobs via retrenchment, and associated job squeeze. The effects of this were many, men who since the colonial era enjoyed clear visibility in the economy were particularly affected by these changes due to the increased unemployment. Imo argues that:

*I am having been looking for jobs. For many, many months I have been looking for jobs, to be able to find a way to help my family. But every day, this will be causing me to be thinking. Every day, I am in the house just thinking, thinking, thinking and I know that this is not good for me. I know because of this thinking, I am worried and stressed up and like I said this stress can cause mental illness (Imo 28).*

Others echoed similar concerns. For example, Yobe, a health practitioner, noted that the absence of Government support equating to "job seekers allowance" as practised in western society's welfare system is disturbing. This was of concern, because many of these men who were unemployed remained unsupported.

This was cited as compounding some of the men's problems as Yobe suggests.

*It is not like the developed countries where the governments help families with financial assistance like weekly money to help family maintenance. But in Nigeria there is no welfare system and the government do not pay weekly money to the unemployed, so the unemployed are left to struggle on their own and this causes stress and led to schizophrenia. In some causes you see that the men just run and leave their home and became insane because they are stressed in the family and just run unto the streets because they can no longer take the pressures and stress of their homes which have now resulted into mental illness (Health professional, Yobe 40-44).*

As indicated earlier the demands of family headship ascribe many responsibilities of the family to the male as head of the household. Zubin and Spring (1977) originated intriguing hypotheses on the role of stress in schizophrenia. On the basis of this, they adopted the stress-vulnerability model, in which demands are very often associated with an increased risk of susceptibility to schizophrenia. This suggests that vulnerability to schizophrenia is a consequence of stressful life events with trying to meet gender roles being an important part of that.

For Anambra and Ogun the effect of children not going to school was stressful.

*When children are not going to school, you will be thinking and this makes you to get worried. As a man, you are supposed to be doing things for your children to be going to school. Every day, you wake up and you see all of your children at home. They are at home and not going to school. But they are supposed to be going to school. And they are looking upon you, that you should make them go to school, but you cannot make them to go to school. You cannot make them go to school because you do not have the means like a job or money to make them go to school (Anambra 37).*

*You will become stressed. Of course, you will become stressed. Because your children are not in school. It was very difficult for me. It was stressful. Every day I became stressed. The reason that, I was stressed was that I was always thinking about how to get money. I was always thinking about how to get money for my children to go to school, so that was what made me to be stressed (Ogun 55).*

The inability to meet family medical needs troubled Osun:

*The other day, my wife had to go for hospital treatment, but it was very difficult for us. As a man you are expected to cover hospital bills. But this was not possible for me. The reason that it was not possible was because I had no job or any money at that time. I was thinking about what to do. This kind of thinking is bad for the man. As you are thinking, thinking you become very worried. This kind of thinking and worrying everyday caused serious problems for all of us (Osun 40).*

Zamfara, one of the health practitioners, noted that money problems were frequently a major concern that exacerbated the men's mental health concerns:

*So that is the big problem for this our society, because most of the men who do not have money to take care of the family are always thinking and this can cause schizophrenia or the mental illness. Because every time they are always thinking, thinking, thinking about how they can play their role as the society believe they must be the breadwinner of the family. But since they are always thinking, then one day they will have a breakdown, because they can no longer cope with the burden of not providing money for the family (Health professional, Zamfara 35-39).*

Ikwuka et al. (2014) have suggested that among the Igbo people of south-eastern Nigeria, many of the concerns about the causes of illness were attributed to life stresses such as marriage, work and finance. Consequently, this raises questions about how some of these participants were conceptualising gender practices and expectations, which might then have an influence on their schizophrenia.

Having explored the data which highlight the pressures of living up to traditional gender expectations and its association to schizophrenia, I will now consider the influence of gender norms, expectations (and shifts in these) on men's recovery from the mental health condition.



## 5.4 Influence of gender on help-seeking

The study findings also bring to light some of the underlying values which influenced Nigerian men's response to mental health difficulties. When discussing the reasons for seeking help, some participants talked about the necessity for well-being, suggesting that a man as family head, took responsibility for his family and the need to be in good health.

As Borno says:

*It is very important that on the first sign of mental illness I go to receive treatment. I have to be well in quick time, so that I can support my family. I am the first male son of my father. And according to the tradition, all of my family look upon me to provide for them. So I have to go out to find a way to provide for them. Even if the sickness do me small, and I see that I am well, than I can go out. The reason is that it important that I put food on the table for all of my family, so I need to receive treatment and be well quickly. Like I say this is important, so that I can help my family (Borno 28).*

In this regard, these participants were more likely to seek help, and family headship seems to have positive help-seeking implications. This is also reflected in the following comments by Bauchi:

*As a man I am the provider of my family. There is no one else that will agree to take all of the responsibilities that you are providing for your family. They do have their own responsibilities. So it will be difficult for them to begin to do for you what you are supposed to do as man. Sometimes, when you think about this, it can make you to get well. And this makes you to go to places that can make you get better (Bauchi 27).*

This sort of comments reflects how perceptions of gender can impacts on help-seeking and also stands in contrast to ideas that men are “irresponsible” when it comes to help-seeking for health concerns. One aspect of this was in recognising that failure to appear at the place of employment (which provides income) might result in family hardship, hence prompting a willingness to seek help: As Kano points out.

*My place of work is important for me, as that is where I chop from. I need to get better to be going to this place that I am chopping from. So, if I see that the place that I am chopping from is going to become a problem, because of what is happening to me then, I need to take some action (Kano 39).*

Moreover, as Jigawa points out, within households- which lack an alternative person to meet family needs, it seems important that help be sought, suggesting that as a man has responsibility for his family there is a need of maintaining good health.

*No other person to provide for my family. What I am saying is that there is no other in my family that can take this role. It is difficult for you when there is no other man to help with taking care of the family. In this kind of situation, you need to make sure that you are always feeling better. You need to take care of yourself properly, because when you fall ill there is no one to take care of your family. Even, when you fall ill, it necessary that you meet people to help you get better, as there is no one to help with taking care of the family (Jigawa 30)*

This was a situation also strongly reflected in the work of Odimegwu and Adedini (2013) with Igbo men in south-east Nigeria. Most of the participants in their study expressed a willingness to participate in health programmes that are designed to address issues that are beneficial. As the results of that study demonstrate, whether a man does or does not assume the sick role when ill can be dependent on the significance the male gives to being the head of the family. However, the danger with this as the data from this current study demonstrates, is that some of these participants might not be getting the rest that they need, and this has implications for their mental health recovery. Delta says:

*Even when I have this illness, I cannot rest. One is not able to rest because you will be thinking of the family. When you have a wife and you have got children then you should be thinking about them. You will be thinking about them because you are the one who they look upon to help the family (Delta 37).*

Taraba a health practitioner supports the concerns raised by some of the men in this study:

*Some of the men are not resting enough, when they are supposed to be resting. Usually they will say to you that there is no need to be resting. Because there is a family demand at hand. So for them this family demand is very important and begins to make them not to have enough rest from the activities that they are doing or that is making them to be ill (Health professional, Taraba 30-34).*

However, it seems that with gender flexibility (Odimegwu and Adedini, 2013; Oluwagbemi-Jacob and Chima, 2015; Oyekanmi, 2015) a departure from the usual masculine expectations can impose fewer family hardships, because how best to provide for family needs becomes more of a shared responsibility.

*And during the time of sickness you cannot do anything, because of the condition of sickness. Nothing that you can do, because it is not you that put yourself in that position, so the woman has to help you, when you are sick. (Lafia 32).*

It is in recognition of this problem that Edo suggests:

*It is important for the Government to help us. If the government can help us then it can be better for us as a man. It will be better for us, as a man because maybe we can have some money. With this kind of money that we are having from the help of the Government we can use it to help our family too, during the time that we are sick and not able to help the family (Edo 45).*

This will be discussed more in the chapter on recovery.

## 5.5 Summary

In this chapter I discussed the theme of gender, where the understanding which the participants' have of gender is often related to the performance of tasks. Traditionally, this definition of gender roles as fixed meant that certain family tasks, particularly tasks related to providing financially for the family, are perceived as appropriate for the male, in contrast to the female. Furthermore, in this chapter, I highlighted how traditional views of gender, where the establishment of household by getting married facilitates status as head of the household and position of breadwinner of their families are still widely held within this community. I then demonstrated how the pressures of living up to these masculine expectations could increase susceptibility to schizophrenia. However, the chapter also shows how many participants were attempting to redefine some of these traditional views associated with men and women, linked to wider shifts in gender expectations in a changing world and the impact this redefinition might have on men's recovery.

## CHAPTER SIX

### “It is the will of God and evil spirits, but sometimes you can get it through hereditary”: RELIGIOUS-SPIRITUAL BELIEFS AND BIOLOGICAL CAUSES OF SCHIZOPHRENIA.

#### 6.1 Introduction

This chapter discusses the perceptions and experiences of schizophrenia in relation to their construction of religious-spiritual and biological themes. In the first section, some of the symptoms cited for the condition are presented, whilst the second section includes data that emerged in terms of religious-spiritual beliefs about the causes of the mental health problem. In the religious-spiritual conceptualisation of the causes of schizophrenia, God’s will, ancestral spirits and Jinn possession emerged as sub-themes. In addition, the chapter also discusses the participants’ views with regarding to biological causes of schizophrenia, where genetic heritability emerged as the sub-theme.

#### 6.2 Symptoms of schizophrenia

The findings of this study suggest that the emergence of an episode of schizophrenia can be observable in changes in behaviour and provides data mainly helping address research question one. Bauchi and Delta talked about the onset of their illness as being characterised by hearing voices.

*When this illness come onto me I was hearing voices. I began to hear voices. Before the mental illness, I was not hearing this type of voice, so I think that before I was normal, because I was not hearing voices. But when this illness start, it was like there was a change. There is a change from the way you are before. That is there was a change from how I was because I started to hear voice (Bauchi 27).*

*I was not my normal self when this illness started. The reason why I say that I was not my normal self was because I experienced some changes when this illness started. Before I did not used to hear this voice but when this illness started there was a change in my behaviour (Delta 37).*

For Cross River his sleeplessness was associated with the emergence of his mental illness:

*At the time that this mental illness start it is difficult to sleep. I was not able to sleep, like I used to sleep well before, but as soon as this problem start you begin to know because you cannot sleep. Even in the night that you are supposed to be sleeping you find that the condition make you not to sleep. You have sleeplessness and one is not able to sleep. I think sleeplessness is the major symptom for this our condition. Because of the sleeplessness then you know that this illness will start (Cross River 28).*

As Ogun also explains:

*Sleeplessness is the symptom that you can experience when this mental illness starts. In my case there is always sleeplessness. Not sleeping is a sign of this our condition. So when you cannot sleep like you used to sleep before, you can begin to feel that this mental illness has started again (Ogun 55).*

In recognition the onset of their mental health problem, Adamawa and Lagos link the condition to their wandering the streets:

*At the time that this mental illness started, I could not stay in one place. That is the problem that I was facing at that time. It because mental illness because I could not stay in one place. I was always roaming from one street to the other. When the ancestors descend on you it is not to stay in one, so wandering is one problem with me (Adamaw 30).*

*I was wandering around the streets without knowing where I am going to. That is the symptom that people say was my problem. The people that know me said that I change in my behaviour and that me to be different from the person that I was before. Even with me when I think about this change that the people are talking about when this mental illness, I will start to remember that when this mental illness started I was wandering in one street now and the next minute I will be in another street (Kaduna 30)*

Another man associates his illness symptoms with public nudity:

*My family told me that I was naked without wearing clothes. That is how it affected me, just not wearing any clothes and being naked. When you are naked you may not feel it unless you are told that you are naked. That is why, I said that it is the ancestors who are at working on me at that time. The only reason why I begin to go naked is because of this thing that they call mental illness (Ekiti 29).*

The Diagnostic and Statistical Manual of Mental Disorders DSM-5 (American Psychiatric Association, 2013) and the International Classification of Diseases (World Health Organisation, 2010) diagnostic manual stipulate that schizophrenia is characterised by the presence of positive symptoms. Defining a psychotic disorder associated with positive symptoms within this diagnostic framework includes hallucinations such as hearing voices and wandering.

The men's description of such positive symptoms linked to the onset of their schizophrenia, was also a feature cited by many of the health practitioners and was seen as indicative of psychotic experiences that lead to the diagnosis of schizophrenia within mental health practice.

*Most of the patients we see have been brought in to us in our psychiatric practice, because of different positive symptoms. In psychiatry we talk about positive symptoms such as roaming the streets, which is what we also identify as a positive symptom describe the psychiatric manual. When a patient begins to roam the street, for example we feel that there is a high risk of the onset of the condition (Health professional, Oyo 35-39).*

*In the psychiatric manual that we use for diagnosis of schizophrenia, you will find that there are some positive symptoms that are mentioned. This includes for example, restlessness, wandering about, and sleeplessness, which are examples of the positive features that aid our diagnosis. So in practice we try to find out what positive symptoms that they might have been experiencing, and most of the times, it means that they are not being able to stay in one place or wandering around (Health professional, Abuja 40-44)*

Similarly, in a study by Yusuf and Nuhu (2010), an examination of symptoms of severe psychiatric disorder in northern Nigeria indicates that talking alone and roaming the streets were suggestive of positive symptoms. Another study by Jegede (2005), where the Yoruba concept of mental illness was examined, included in-depth interviews with 10 traditional healers (herbalists) in Ibadan, Nigeria. It was found among the Yorubas that the onset of mental illness is observable in the change in behaviour of individuals, where symptoms of the illness includes "aisun" (sleeplessness) and "aiwo" (restlessness). This might also be the idea behind Iroegbu's (2005) views where insanity in the traditional Igbo land of south-east Nigeria was referred to as behaviour which is at odds with the expected behaviour in the household and society.

This view is not limited to Africa. From a total of 49 participants responding to a request for field trial in United States, Regier et al. (2013) found that hallucinations are a core symptom of psychotic patients, reporting that schizophrenic individuals overlap positive symptoms between auditory and visual hallucinations.

Alongside the positive symptoms associated with the onset of mental health problem, other participants' referred to negative symptoms linked to the condition. For example, these comments by Osun and Kebbi indicate how the onset of their illness was associated with a lack of interest in daily activities.

*My symptom was my lack of interest. I did not have interest in anything that I used to do. Before you can have this interest in doing some things but I think that when this illness starts you will loss all the interest that you used to have. Some people say when you lack this interest you must begin to be careful because the mental illness is about to start again (Osun 40).*

*Always I used to stay in my house, without going out of the house. Before I used to leave my house to go out but during this time that this sickness started I always remain in my own house. I no longer want to leave my house. I think that is when you can begin to think that this illness has come. So for example not wanting to leave the house is a symptom of this sickness. It is a symptom of this illness because when the illness starts you have lost interest and then you just continue to remain in the house, because the illness has made you to lose interest (Kebbi 24).*

As Katsina says:

*At that time I lack interest in talking to my family. Because of this lack of interest I was not talking to any member of my family. I can say that I was less likely to initiate conversations with my family. You feel that you want to do what you used to do before but you lack the interest to do what you are doing in the past. This lack of interest is certainly a problem with this our illness (Katsina 27)*

In a sample of 70 Nigerian patients diagnosed with schizophrenia at the Obafemi Awolowo University Teaching Hospital in south-western Nigeria, Aloba, Mapayi and Adesanmi's (2014) study assessed symptoms associated with their condition, where negative symptoms reported included lack of interest. In Denmark, a sample of 300 patients with a first-time diagnosis of schizophrenia were assessed for psychotic symptoms in Uggerby et al.'s (2013) study. Many of the service users' diagnosis were found to fulfil the International Classification of Diseases (World Health Organisation, 2010) diagnostic criteria for schizophrenia such as presence of negative symptoms including lack of motivation. As one health practitioner in the current study noted:

*There is a lack of willingness to do anything. There are many of the men that lack the willingness to be involved in any activities. For example, they might not want to leave the house or lack the willingness to take care of themselves, due to the presence of these negative symptoms, which impact the patients' abilities to be interested in daily activities (Health professional, Plateau 35-39).*

Similar insights to the mental health problems associated with their illness recognised by the men in this study included cognitive symptoms.

*Lack of concentration is the big symptom with this mental illness that they call schizophrenia. As I understand the sickness that I was experiencing was lack of concentration. I don't know what the problem is but I was not able to concentrate. When I was myself, before the sickness, it was different, because I was able to concentrate, but when I was not myself this change started and I was not able to concentrate during that time (Jigawa 30).*

*The problem with me is with my condition coming over me it was not easy to focus. What I mean is that it is not easy to put your mind on one thing. That is what I mean by lack of focus. Even when someone tell you something now you might not be able to follow what they have said to you, maybe because you don't remember and this mental illness is affecting what you can remember. That is for example, you have what they call poor memory (Adamawa 30).*

This might be the idea behind Opler et al's (2013) observations about cognitive deficits in schizophrenia, where difficulty of focusing, following instruction and poor memory were most frequently cited as impacting functional outcome in schizophrenia. As Yola one of the health practitioners suggests:

*This thing that we diagnose as schizophrenia, also affects their cognition, and that is what we refer to as cognitive deficits. In the manual, you will find that this refers to difficulties in the understanding of instructions or in focussing at a particular task. You find that when patients have cognitive deficits it can also affect their concentration, because of the difficult in being able to focus on any particular assignments that may be required (Health professional, Yola 25-29).*

Positive symptoms, as well as negative features and cognitive deficits, were found to influence how the men understood the onset of their condition. These symptoms, associated with the emergence of their mental health condition, also increased the risk of self-harm.

*This voice was telling me to kill myself. I don't want to kill myself but the voice is telling me that it is a good thing to do. Before when I don't hear this voice I am okay. But when I begin to hear this voice telling me to kill myself then I know it can make me harm myself. Every normal person that I know do not want to kill themselves, but it is because of the symptoms of this mental illness that you want to kill yourself (Kano 39).*

*When the voice is talking to run away from my house. This is the house that I am living with my family, and I am happy to live with all of my family. But this voice is bad one and when a bad voice is talking to one it talking about a bad thing. This bad thing that the voice is telling me is to leave my house and run away from my family (Imo 28).*



Kwara and Kebbi also referred to the symptoms that they were experiencing as increasing their likelihood to harm others.

*During that time when it is night time and everyone is sleeping in my house, it is like this voice is commanding me to burn down the house. I will be fighting the voice that it is night time and people need to sleep in the house, but I think the voice is telling me to burn down my house. I am afraid because I do not want to burn down my house. But when this voice is commanding you it can be difficult (Kwara 42).*

*I used to wander around the highway. In this highway there are plenty vehicles and this voice was telling me to break the cars that were passing on the road. It is not my own car but the cars belong to other people, but this voice is telling me to break the windscreen and damage the car (Kebbi 24).*

This view about the role of psychotic symptoms increasing the risk of self-harm or harm to others was not limited to the men, as the following comments by the health professionals Taraba and Zamfara demonstrate.

*The experience of psychotic symptoms can be very disturbing for the patient. That is why some of them during this period of the onset of the symptoms can harm themselves. Apart from the danger of harming themselves, you may find that the experience of these symptoms can lead them to harm others (Health professional, Taraba 30-34).*

*For some of these patients, when you interview them, you find that some are being commanded by the voices that they may be hearing to harm others or to harm themselves. Some of these patients are wandering the streets as well and then there is the danger that they might be harmed or harm others roaming the streets (Health professional, Zamfara 35-39).*

It has also been reported within the literature, that people with schizophrenia are at high risk of self-harm or harm to others (Honings, et al., 2015; Lawal et al. 2014). In one study by Honings et al. (2015), where a systematic review of studies reporting on the risk of self-harm was conducted, psychotic experience was associated with suicidal ideation as well as suicidal attempts. Also, the results of a Nigerian study by Lawal et al.'s (2014), where the relationship between psychiatric disorders and crimes was explored among violent offenders in a community in south-west area, it was found that the majority of offenders accused of violent crimes attributed it to their mental health difficulties.

The current study findings also brought to light the disruptions to daily activities associated with the onset of schizophrenia. When some participants spoke about this, there was a concern that their mental health problem was conceptualised as a disruptive condition, characterised by an inability to meet the demands of their daily living.

*The illness will disrupt your activities. What you used to do before the mental illness started, you won't be able to do once it starts. It is very difficult to have a normal life once this condition descend on you. It is difficult to do your daily activities because you have impairments and all of these impairments brings difficulties for you to perform your daily tasks (Enugu 42)*

*I could not do anything in the house at all. Before the time that this thing happened I used to go out and do small work, but when it started I could not do anything. It brought me down. Even the going out to do some job that I was doing before I could no longer do (Abia 29).*

Such disruptions linked with their condition can also hold participants back from joining in with groups or in activities that might be helpful to sustaining them or contributing to their recovery. Niger, a construction worker, who had been employed at the time of the onset of his condition, talked about how the emergence of his mental health problems disrupted his employment along with his career ambitions.

*I used to work as a construction worker and I really liked it because I was planning to have my own company. But this time that this my mental illness started I was always wandering. I was wandering and didn't find the place that I was working. Even when I wake up early in the morning to go to the place of my work, I will wander into the bush without knowing where my job place is. Because of this wandering and not knowing my place of work, I was unable to continue with the work (Niger 38)*

One man, normally friendly and sociable, experienced the mental health condition as affecting a change in his behaviour and causing him to become withdrawn or to have difficulties in establishing the daily contacts that most people would need for performance of their job.

*When I became withdrawn I did not want to go to work. Before I think that I was friendly and was not isolating myself from work, but as soon as this illness start on me it affects my abilities to do the job. As you became withdrawn, you lose interest to go to work. That is what I mean that when you are mentally unwell you cannot go to work (Anambra 37).*

In Nigeria, Campbell et al.'s (2015) study provides insights into the difficulties which can be associated with schizophrenia and employment. Their study among outpatients at the Lagos University Teaching Hospital, found a significant level of unemployment related to the disruptions caused by psychotic symptoms. This finding is similar to what has been found among people with schizophrenia in the United Kingdom as reported by Knapp, Mangalore and Simon (2004) where schizophrenia has been associated with an increased risk of unemployment.

*For two years now I was unable to work. It is very difficult for me to work. My body could not take it. I am trying hard to work but my body is just not taking it. It is like when you have this condition you become very tired so this affected me. The reason that I say it affected me is that small time I will become tired and this make me not to be able to do any work (Lafia 32).*

This profound sense of disruptions associated to their mental illness, and often linked to the symptoms of the mental health difficulties and its disruptive impact on some of the men continuing their education.

*I could not concentrate. Because I could not concentrate, I was not able to focus on my studies. I feel like you can't live anymore. That is the big problem because my condition affected my studies. It made me not to focus on my studies. Even my WAEC, I was not able to write my WAEC (Lagos 22).*

*My education was affected. I was not able to continue with my education. You know when the conditions take over you, it can be difficult to sit in one place for any time and trying to become involved in any education can become impossible (Gombe 23).*

Taken together, before being diagnosed with schizophrenia there seems to be a wholeness in how the men understood themselves, how others perceived them and how they functioned in their lives. However, this image and identity of themselves as promising individuals often began to crumble during the emergence of "mental illness". It was as if they had become viewed as fundamentally ill, broken and unable to function as their society expected. The symptoms associated with the onset of their mental health problem was characterised by changes in the men's behaviour. For instance, many daily living activities seemed to present difficult tasks both mentally and physically. The development of a mental health problem like

schizophrenia is therefore viewed by the men, their families and by health professionals as disruptive to everyday situations.

Having highlighted the symptoms associated with schizophrenia, which show the condition as a disruptive illness, I will now turn to consider the data in relation to religious-spiritual beliefs about the cause of the mental health difficulties.

### 6.3 Schizophrenia as a religious-spiritual phenomenon

The views that individuals hold about mental health difficulties may stem from beliefs held in their society about the condition (Adewuya and Makanjuola, 2008; Dein, Alexander and Napier, 2008; Khalifa, et al., 2011). People with the condition and their carers' are likely to share these beliefs held in their society in relation to the causes of mental health difficulties, which in this part of Nigeria, includes religious-spiritual beliefs. Therefore findings from this study suggests that mental ill-health can be partly understood as a religious phenomenon being God's will, but also recognised as ancestral and Jinn possession. Underlying this religious-spiritual conceptualisation of the cause of the condition was the explanation that affliction was brought on by God and/or spirits due to one's sinful ways.

#### 6.3.1 God's will

For some participants', there was a strong desire to talk about mental health difficulties in religious terms. When these participants' explained these religious beliefs, it seemed to centre on connectedness to God and to encompass their relationship with God (or a higher power), with God being seen as a Supreme Being or Creator.

*It is God's will. That is if we are to take it from the religion point of view, then we can say that it is God's will. God is supreme and the creator. As the supreme being of everything, that is as the creator means that things can happen through God's will. This God's will is strong. So if it is the will of God that this problem comes over me, then it can happen to me. God's will is supreme. Because it is God that makes everything, so God makes all things to happen (Abia 29).*

This kind of view was strongly expressed in a similar study carried out by Adewuya and Makanjuola (2008) in the south-western part of Nigeria, where members of a population that regarded themselves as religious suggested God's will/divine punishment as a causal belief. As Ondo, one of the men in this current study suggests, the only plausible explanation for his mental health problem was that God (the ultimate cause of the illness) had inflicted the condition upon him:

*Religious way is the way to understand this illness. Because when you ask yourselves the reason why this happening to you and not another person, then you begin to understand that it is God's will. God is the ultimate cause. With every illness like this, we need to know that God is the cause. God as creator is the cause and we cannot argue with this situation, as God has made it to happen (Ondo 36).*

Although there might have been some understanding of God being responsible, there was also disbelief, as some had trouble with the idea that they might have a mental health problem.

*When this illness happened to me, I could not believe that it is what they are saying is mental illness. But one of the reasons was that I was going about naked. When I was go about naked without wearing any clothes to put on my body. So I was not wearing any clothes on my body. But I did not know about this condition. It is difficult to know about this kind of conditions, when you are unwell. The only thing is that you can do some things that can offend other people. Like in my case, I was not wearing any clothes on my body, and this was not good for me and for the other people (Gombe 23).*

Significantly, Imo conceded that it was God's will and his explanations as to why is reflected in his comment below:

*It is because of this that you begin to try to find out the reasons for what is happening. When your family see that you are not behaving well then they can begin to ask for the reasons for this kind of illness. As God who said it should happen, but as it cannot just happen like that then, you have to go and find out the reason (Imo 28).*

No single explanation is likely to offer a complete understanding of the relationship between religious beliefs relating to mental illness exhibited by the participants in this Nigerian setting. However, contemporary analysis of concepts of mental illness suggests the idea of self-blame is important (Adewuya and Makanjuola, 2008; Bojuwoye, 2013; Tatira 2014). This seemed to be premised on the idea the person with mental illness has offended God. As Kogi and Ekiti points out, essential to this view is the notion of behaviours which might displease God.

*I think I have got myself to blame for this. God does not disturb you like that. So I think I have got myself to blame. It is difficult to say. When you stay before without this illness and then later this kind of illness happen to you then you begin to ask yourself why. The reason you can find is that something that you have done is not right. It is good to do nice things, but when you do something that it is not nice, then this kind of illness can descend upon you (Kogi 31).*

*In our society, we have some kind of behaviour that one is not supposed to do. That is there are things that one is expected to stay away from. When you stay away from these things that are not allowed or forbidden then you cannot offend God. So when something like this happen to you, it is God that is not happy. When God is not happy something like this can happen to you. God will not be happy if something that you are doing is not good. So this kind of things can come upon you when God is not happy with something that you are doing (Ekiti 29).*

One implication of ascribing mental illness to God was that such lay health beliefs might be a major contributor in explaining why some people have a negative attitude to psychiatry in Nigeria. As Nasarawa observes, God is the creator and also the healer:

*God makes people. So, God made it possible by the fact that he created and raised people that we call doctors and we also have those we call pharmacist, who discover these drugs, from their original form, that is herbs which now lead to medicine. The existence of medicine comes from God. And the doctors and nurses that take care of patients are also helps from God. They are people that God decided to help people who are victims of sickness. So that is the sense that God comes in. God uses people to help. God give people wisdom to discover medicine that can cure people from whatever condition that they are experiencing (Nasarawa 27).*

Adeosun et al. (2013a) also argues that, members of a community that regard themselves as religious may perceive doctors as failing to understand or consider their religious beliefs. This might be what underlies Odinka et al's (2015) comment that help-seeking among service users with schizophrenia in south-east Nigeria was influenced by the conceptualisation of their problem in terms of religious-spiritual beliefs. Another possible implication is that to turn to a western-type mental health practitioner may express a lack of faith in God's ability to help.

*I believe in God's power to overcome this illness. So I turn to my God. In all that is happening to us it is God that sees us through. When you have God behind you, there is no problem. So I turn to God, who has said that this thing should happen. It is God who has said this should happen, so it God who will also decide for it to go away. That is why I said it is important to believe in God, for whatever that has happened by God, it is also possible for God to make it right (Kwara 42).*

Alongside God's will some of the men also cited spirits possession as a possible cause of their mental health problem, and this will be discussed further in the following section.

### 6.3.2 Ancestral spirits

The onset of schizophrenia, through affliction by ancestral spirits was highlighted by the findings in this study. The underlying belief is that there is a continuous communication between the dead and the living and, thus, after death, though the body may disappear, the spirit lives on. These spirits are believed to play an important role in maintaining the wellbeing of their living descendants. In contrast, it is also believed the ancestral spirits can inflict punishment through afflicting people with mental illness if societal norms are violated, or when culturally prescribed practices are neglected or incorrectly performed.

As Niger explains:

*Mental illness is spirit possession by ancestors. I mean that my case is that something inflicted on me from the evil world by my ancestors. They used evil spirits to possess attack on me. It is something you cannot see with your own eyes, but they are attacking you. This I got to know from people that are praying for me and I got to know myself. What you cannot see, like witchcrafts, wizard, all these kind of things. There are good ones among them it is not all witchcraft and wizards that are bad. That is why I believe that my case is not medical but by this people who are the angels of darkness (Niger 27).*

Others echoed similar views. For example, Nasarawa indicates ancestral spirits as being responsible for his mental health problem:

*"It is not by own wish to be a mental person. It is ancestors wish to be the way I am. What I mean is that the ancestors have a hand in mental illness (Nasarawa 27).*

Adamawa, also commented about this:

*That is the first time it started, I was hearing voices their voices, when the illness started. That was the first time the sickness started. I was hearing voices from the spirits. Because of this I was restless and I became to wander like roaming around our streets. It was not the spirit of God, it was the spirit of the evil boy who was reminding me to go out so that the can destroy me more (Adamawa 30).*

Other writers have discussed traditional African beliefs that demonstrate an association of mental illness with ancestral spirits. In one such work by Mpofu, Peltzer and Bojuwoye (2011) they focussed on traditional beliefs in Malawi and reported that a maternal grandfather was believed to be responsible for the individual's problem, whilst the paternal grandfather was believed to be a good spirit and protective father. Among the Shona people in eastern Zimbabwe, Tatira (2014) reported on their beliefs in ancestral spirits, where it was suggested that many believed in the influence of mudzimu (ancestral spirit). Bojuwoye (2013) also discusses the traditional beliefs of many indigenous cultures of Africa, associated with ancestral spirits and the notion of controlling events in life including inflicting mental illness.

This view is not limited to Africa, as shown in a study by Betty (2005) where mental health problems in China, India and the United States were associated with the spirits of the dead who are not at rest. Thus, it seemed that when it came to understanding traditional views about the causes of schizophrenia, there is a belief in a spiritual link. As Bayelsa says:

*Yes, spiritual in the sense, that we know that God is a spirit itself. And that spirits exist. The fact that we believe that our Almighty God is a spirit in also a sign that spirits exist. God is the supreme supernatural spirit, from whom other spirits emerge. The angels of God and the angels of Satan are different. So these spirits of Satan is the one that came on me, when I was in the University. You know demons can perch on you and if you allow them, they will create mental illness. They will creep into your life and where they are there, they will control your life. They make you to lose control of yourself and they try to impose themselves on you (Bayelsa 34).*

Some of the men gave explanations for affliction by ancestral spirits. One explanation given related to breach of taboo. As Ekiti says:



*For us there are some things that are forbidden. Forbidden because you are not allowed to do them. This is what we call taboo. So when you know that something is taboo than you have to stay away from doing that can of thing that is bad. You must stay away from that taboo, if not you can get mental illness, because it is a taboo and you have done something which is forbidden (Ekiti 29).*

To amplify this point, Afe (2013) adds that in traditional Yoruba societies of south-west Nigeria, taboo represented a source of guiding principles regulating and directing the behaviour of individuals towards the Supreme Being especially the gods and ancestors. However, if such taboos were not respected certain gods would be displeased. It was in this sense that some of the men describe taboos in similar terms suggesting they represent a system of prohibitions with regard to certain persons, things, acts or situations. The objects considered as taboo are perceived to contain within them certain assumed rules that always have repercussions against anyone who transgresses them.

As Delta explains:

*The first one, now traditional doctor I first see they told me there is some food that I cannot eat. There is some food that I should avoid, so that it does not come back. There are some foods that I do not eat for now. And there are some that I eat. What the native doctor told me, I followed it, until today. There are some foods, that I cannot eat in life, if I don't eat it then it would not come back again (Delta 37).*

There was also a belief that mental illness can be brought on by being ritually impure due to engaging in an activity believed to be unclean, such as cannabis usage. As Ondo says:

*Well to be honest, I think I offended the spirits by my usage of marijuana. Marijuana is a taboo in our culture and it is because I was using it that spiritually I became unwell. Even when I went to the traditional healer, he told me indulgence in bad things like smoking Indian hemp, will make my ancestors angry, because it is taboo and against their wish for their son (Ondo 36).*

This knowledge could be regarded as good as recognition of the possible spiritual effects of using illicit substances may restrain some people's use of such drugs. However, another perhaps more adverse feature of this notion is that an individual's mental illness could be

viewed as a moral lapse or as self-inflicted, therefore increasing the negative attitude towards the men.

*My friends have left me to be alone by myself. They blame me for this illness. They are all saying that I caused it for myself. When I try to explain to them that it may not be my fault, they blame me saying that it because of the things that I was doing in my life which is forbidden in the eyes of spirits that have caused me this problem. They said that according to their belief in God that their Supreme God does not tolerate this kind of behaviour and anybody who continues to use this kind of drugs will make God not to be happy with him (Abia 29)*

*Even the people in your family will not want to associate with you because they believe it is self-inflicted. When you come to them they will be running away from you. They do not want to have anything to do with you, because they say they have told you to stop this kind of behaviour which offends God and the spirits yet they not sure that I have stopped it (Ogun 55).*

When some participants' furthered their explanations about spirits possession they talked specifically about the impact of violations of sexual prohibitions.

*During that time, I would say I had a girl, I would say my girlfriend and I was very small at that time. One day there was nobody in the house and we went to the bush together with this girl to have sex. I was a teenager I don't know anything at that time. But I can say that even the Bible said it, that fornication is a sin against your own body and I know that led to my mental disturbances, because if you done something that is not right the ancestors will not be happy and they can cause you mental illness. Because of this it is good not to do bad thing (Gombe 23).*

As Afe (2009) work in southwestern Nigeria suggest, it was forbidden for family members to marry each other. As that work also indicates, incest or a sexual act within the family was noted as an abomination. It is in this context that individuals who engage in such behaviour can be afflicted with mental health difficulties as these actions offends God and the spirits.

In this study, the association between spirit possession and mental health difficulties is not limited to ancestral spirits but can involve other forms of spiritual influence.

### 6.3.3 Jinn possession

As the data demonstrate, similar beliefs relating to Jinn spirits were held among some of the participants', when they talked about their beliefs about the causes of mental health problem.

This is reflected by the following comment by Katsina and Ogun.

*I used to be seeing strange things doing, like I used to see a dog chasing me. Sometimes it is chasing me, and sometimes it started to talk to me. This disturb too much I cannot even perform my prayer or even to perform ambulation. I believe it is Jinn that caused it. Because sometimes you see Jinn can possess you and this kind of spirit can cause you to have mental illness. Even, when I went to see mallam he said it is "Jinn" that cause the problem. So that they would now reverse the jinn from the body of that person (Katsina 27).*

*This problem is caused by Jinn, which can descend on you and cause one with mental illness. What I mean is that we have different spirits, that is some people believe in different spirits, but in my own case what cause this my problem is Jinn (Ogun 55).*

Such spiritual beliefs are also not unusual in the Muslim population of the United Kingdom population today. Studies have suggested that some Muslims hold strong spiritual beliefs. For example, Khalifa et al. (2011) suggested that a large proportion of individuals of Islamic tradition in Leicester believe in supernatural forces. In their survey, a majority of individuals reported that they believed in Jinn, many believing that Jinn was the cause of mental illness. These findings corroborate other findings among the Bangladeshi Islamic population of East London, where Dein, Alexander and Napier (2008) found many of the participants had attributed mental illness to Jinn. There was a similar finding reflected in Mali, Africa, where among fifteen service users, symptoms of schizophrenia such as hearing voices were often explained in terms of local beliefs about Jinn possession (Napo, Heinz and Auckenthaler, 2012). These studies also suggested (Dein, Alexander and Napier, 2008; Khalifa, et al., 2011; Napo, Heinz and Auckenthaler, 2012) that individuals trusted religious healers to be the authority in treatment for such illnesses.

Adamawa and Benue talk about how they learnt that Jinn could be cause of their condition.

*Like I said this is because of our Islamic beliefs. But my Islamic beliefs do not contradict what is in the Quran. It is what is according to what is written in the Quran (Adamawa 30).*

*The Holy Quran talks about Jinn. If you take the book and read it you will find that it is talking about Jinn. As a Muslim when you read the Holy Quran then you will understand what I am talking about. What is written in the book of God is what we have to believe in. It is when you have beliefs, then you have to look where this belief come from. And when you take it and go and read the Quran then you can see that my belief in Jinn as the cause of the mental health problem is written there (Benue 30).*

Together these findings demonstrate the importance of maintaining harmony between God/spirits (invisible world) and human beings (visible world), such as avoidance of acts that might offend God/spirits. Thus, another feature here is the idea of spiritual/moral codes intended to create societal harmony. To preserve this harmony is the duty of the individual as a breach of that which is forbidden can incur the wrath of God and spirits in the form of mental health problems (Lim, Hoek and Blom, 2014).

The onset of mental health problem is noted as disruptive to the men's activities of daily living and, their conceptualisation of the cause of the condition highlights religious-spiritual beliefs. However, as the views of many health practitioners in this current study demonstrate there may be tensions in lay men's understanding of schizophrenia through a religious-spiritual framework:-

*Beliefs in religion or more precisely in God as the cause of patient's schizophrenia is difficult to understand. It is like having delusion, because it is cannot be proven in psychiatry. That is the problem we are facing in practice, because these patients come to tell you that it is God that have caused this problem for them and they want you to believe them as well. But it is difficult to believe because in psychiatry there is no proof for this (Health professional, Sokoto 40-44).*

*Some of patients that we come across in our practice, also profuse that one kind of spirit or the other type of spirit is responsible for their developing schizophrenia. It could be somebody that died and it is not happy with them, but without disrespect to the service users, it is impossible to link schizophrenia to something like these spirits that you cannot see (Health professional, Rivers 35-39).*

When the majority of the health practitioners spoke about this, there was a concern that the men's conceptualisation of their mental health difficulties as a religious-spiritual phenomenon

involving supernatural punishment by the evil ancestral spirits also links to men's wider experiences of health, and this will be discussed in more detail in the following chapter.

*They will tell you that God has caused this problem for them and God can help them to get better. Some of them will tell you that it is the evil spirits that have caused this problem and that they need to talk to the good spirits to help them get better (Health professional, Yobe 40-44).*

Alongside, these religious-spiritual beliefs, the findings highlighted alternative explanations about the possible causes of mental health difficulties, where biological causal factors were cited.

## 6.4 Biological causes of schizophrenia

In a previous study conducted in Sweden, schizophrenia was found to have a multi-factorial biological aetiology with birth complications, genetics, and substance misuse found to be significantly associated with an increased risk of later schizophrenia (Harper, Towers-Evans and MacCabe, 2015). This link to a biological origin of the men's problem was realised by men in this study.

*I believe that my case is not spiritual it is biological, that is when you have this kind of bad gene. You know that some person can be born with a particular gene that can cause him to mental illness. So when you get a bad gene from your family, then it can cause you mental illness. Because this type of gene will pass the mental illness from one family to another (Ebonyi 40).*

*There is the type of gene that can cause the mental illness. As I human being we have different genes and some of them can be different. Even in the family and like our parents have different genes too. So the gene that one mother have can be different from the gene that the father has. So if the mother has a gene that can bring this condition that one can get it from them (Kaduna 30)*

In Alejandra et al.'s (2015) multi-Latin America countries study, an exploration of the causes of schizophrenia was carried out. An explanatory framework which distinguished the causes of schizophrenia into biological, psychosocial and magical-religious explanations was utilised. Responses to the conceptualisation of the causes of schizophrenia in their study, reflect a

biological explanation where schizophrenia is associated with a genetic risk component. Furthermore, this conceptualisation of the possible biological/genetic cause of schizophrenia found within the literature and echoed by the men in this current study, is also supported by views held by many of the health practitioners interviewed.

*I think that there are different possible causes of this mental illness? In terms of the biological cause it is more likely that someone, who has a family history of someone with schizophrenia is more likely to experience the onset of the illness (Health professional, Zamfara, 35-39).*

*It is not only one factor that can cause schizophrenia. The biological factors that can cause the condition can be many. You can find that in one family there is no responsible gene to cause the condition, so the family can be free from the condition, but in others you find that there is one type of gene that can cause the problem, that is why we can begin to take the position, one with a family history is likely to have the condition (Health professional, Plateau 35-39).*

Kendler (2015) in the United States, also linked the biological cause of schizophrenia to genetic risk factors and this view has also been reflected in some African countries. A review of the literature found a similar biological factor in Bulbulia and Laher's (2013) South Africa study among psychiatrists in Johannesburg, where schizophrenia was attributed to genetic predisposition. In a study among Nigerian families, Omoaregba, James and Eze (2009) also found that the risk of developing schizophrenia is higher among persons with an affected family member compared to the general population. Similar comments in support of the views expressed by the men and the findings in the literature are illustrated by Oyo, another health practitioner:

*In psychiatry we talk more of risk factors interacting to cause schizophrenia. We are talking about the genetic link-up of an individual which in clinical setting we identify by someone, who is having a family history. Someone, who has a family history of someone who has schizophrenia, has a higher tendency of developing schizophrenia later in life (Health professional Oyo 35-39).*

Such that genetic risk factors involve a process through which individuals acquire at conception certain vulnerabilities to schizophrenia. A similar position was argued in Harper, Towers-Evans and MacCabe's study (2015) where it was reported that if both parents receive a diagnosis of schizophrenia, this contributes to the increased risk of their children acquiring schizophrenia. As indicated, similar observations about the heritability of schizophrenia have

been made in some studies carried out in Africa (Bulbulia and Laher, 2013; Omoaregba, James and Eze, 2009).

There could be several reasons why some participants in this current study recognise the likely cause of schizophrenia in terms of a biological genetic risk factor and seemed to be mostly related to the men's own family experiences:

*Experience with this kind of illness is important for you to understand that it can be a biological problem. In my own case, I can say that because one person in my family has this mental illness that was the reason why I got it. You know that when one thing happen to one person in your family that it is likely to happen to another person (Jigawa 27).*

*I know this family that one of the parents have this mental illness, and I think it is because one of the parents have the illness that the son they born had the illness as well. During a long time ago, people in the village were saying that one of the parent was in hospital for the same type of mental illness the son is now experiencing. When one parent experience this kind of illness and was put in hospital for it, then that experience of you knowing that family and knowing what happened to them and make you to believe that it is a biological sickness (Ogun 55).*

In this current study, contact with mental health professionals was cited as a contributing factor influencing the men's perceptions of schizophrenia. Both Kebbi and Gombe suggested that the explanations they received from their mental health practitioner, aided their conceptualisation of biological factors as a cause of schizophrenia:

*From what the doctor what saying I think it could be biological and maybe not spirits like I was thinking. Sometime as a person you may think one reason, but when doctor explain to you, then you can begin to think of that it is not like what you are thinking. So the doctor explains to me and it help me to understand that it is biological. That is something that you can get from family. Maybe if one of your family person has it, say your parent have it (Kebbi 24).*

*Before, I did not believe this mental illness can be caused by the biological things that are happening in the family. But when the psychiatrist in the hospital that I attend, was explaining everything to me that certain things that happened in the family can cause mental illness. It is from his explanation that I began to think that may be it is biological (Gombe 23).*

In the United States, Esterberg and Compton (2006) had similarly observed within a sample of African-American carers of service users that views of biological causes of schizophrenia were

prevalent. This position was also reflected among Australian carers of service users with psychosis attending youth mental health services in Clarke and Couchman's (2012) study where contact with health professional at mental health facilities was a significant influencing factor in their endorsement of a biological causal factor.

It seems this biological conceptual model or explanation for understanding mental health problems, has implications for recovery and this will be discussed in the next chapter. However, an example of comments associating schizophrenia with a medical condition requiring medical attention is reflected in these comments by health practitioners.

*Mental illness is like malaria where if you take tablets and it can go away. But you need to take tablets for something because the sickness is likely to have affected your blood and it is not something that you can quickly recover out of it, if you do not take tablets (Health professional Yobe 40-44).*

*In my view, as schizophrenia is caused by a biological problem, it seems that it is necessary to consider it as a biological condition. That is why our practice is, we try to find out the biological condition responsible, and to diagnose this condition in light of our investigations. As soon as we complete this biological investigation we have to recommend medications (Health professional, Abuja 40-44).*

From this point of view, it appears that the decision as to whom to ask for help was substantially influenced by the perception of the cause of the psychiatric disorders. Participants who perceived mental disorders to be caused by biological influences (such as variant genes) were more likely to recommend medical support. Read et al. (2006) added that "an illness like any other" approach could be responsible for the stronger desire for a "biological disorder" paradigm providing the scientific basis for psychiatric medications.

This explanation has been strengthened by Furnham (2009) who suggested that the majority of 185 British adults surveyed indicated that drug treatments were more effective for treating schizophrenia as the condition was recognised as having a biological basis. In Germany,



Wiesjahn et al. (2014) carried out an online study of participants with self-reported psychotic disorder. They reported that individuals with perceptions of biological causes of schizophrenia generally likened it to a medical condition. They further argued that this biological belief in the causes of schizophrenia influenced the acceptance of medication.

## 6.5 Summary

In this chapter, I discussed some of the symptoms associated with onset of schizophrenia and how the participants' talked about the disruptions to daily activities linked to emergence of the mental health difficulties. I also discussed religious-spiritual beliefs about the condition associated with God's will, ancestral spirits and Jinn possession. Despite the mysteriousness of some of the concepts, the findings in this chapter provide good reason to think that religious-spiritual beliefs within a traditional Nigeria context influence the men and their family's interpretation of the men's mental health difficulties. This belief of supernatural punishment by God or evil ancestral spirits markedly differs from biological explanations for schizophrenia. One implication of this is that a rejection of psychiatry is not uncommon to many with such religious beliefs.

Having provided data on religious-spiritual beliefs and biological causes of schizophrenia, in the next chapter I turn the focus of this thesis to understanding the factors that influence men's recovery.

## CHAPTER SEVEN

“It is not only one thing that can make you get better from this kind of mental illness. I think there are different things which all can help in different ways to help you get better”: EXPLORING RECOVERY AS MULTIFACTORIAL.

### 7.1 Introduction

In this chapter, I discuss the perceptions and experiences of schizophrenia that emerged from the data in relation to a recovery theme. The first part of the chapter focuses on participants understandings of recovery and comprised three sub-themes: recovery as getting better, symptoms relief and return to expected roles. The second part of the chapter focuses on factors influencing men’s recovery from schizophrenia within a community in northern Nigeria. Three sub-themes emerged: western medicine, traditional medicine, and family support.

### 7.2 Definitions of recovery

The results presented in the previous chapter highlighted the nature of schizophrenia, where its onset was discussed as overwhelming for the person impeding activities such as employment or education. Schizophrenia was therefore described as a mental health problem characterised by symptoms, which disrupt an individual’s activities of daily living. How the men managed their condition once it had been diagnosed and what helped or hindered their recovery were explored with the men resulting in a deeper understanding of their experiences.

#### 7.2.1 Recovery as getting better

Although the onset of schizophrenia was often talked about by the participants in this study as observable in psychiatric symptoms which impede the ability to function in activities of daily living, recovery is often defined most simply as “getting better”.

*It is about getting better. When the person was ill, he has all these problems and because of this he cannot do much because of all of these conditions that are affecting him. During this time the problems make it difficult for him. But say after he begins to feel better may be two month after he begins to feel better, so I can say that he begins to feel better and get recovery (Adamawa 30).*

*When someone is getting better from a previously diagnosed illness, then I think he is recovering. Sometimes when you are sick you, they can diagnose you for these conditions. What I can say is that this illness that you have been diagnosed with is not a small thing. It is a very big condition to make you have this kind of diagnosis. So when you begin to feel better from this previous condition that you have been diagnosed that is recovery (Akwa Ibom 30).*

Similarly Bauchi talked about his understanding of recovery as characterised by getting better.

*Before you were a normal person, but during the time of this mental illness that they call schizophrenia your whole conditions changes from your normal self. That is how people know that you have the sickness. But when you start to get recovery you will see that you begin to return to your normal self again. There is a getting better in the problems that are disturbing you in every day of your and you feel better (Bauchi 27)*

This understanding of recovery as “getting better” is representative of views also expressed within Lemay et al.’s (2011) literature review of the concept. In that study (where a total of 97 papers were reviewed), the main concept of recovery identified described it as journey involving “getting well”. Kalachi et al.’s (2011) study looking at participants’ understanding of their recovery further suggests that the “getting better” journey includes improvements in their mental health problems.

As one health professional here concurs:

*I believe recovery is about getting better. What this means that with the onset of schizophrenia, patients are unwell, but with them getting better comes the idea of recovery. In clinical practice, there are a number of things that can help the patients to get better but generally, recovery involves getting better (Health professional, Taraba, 30-34)*

### 7.2.2 Symptoms relief as feature of recovery

One way in which the men in this study reported feeling better related to the symptoms that they were experiencing. A majority of the participants saw a relief from their mental health problems, or even being symptoms-free as a clear sign of getting better, of recovery.

*The man can have a relief from his illness symptoms. That is the way that I understand my recovery, as being a relief from the symptoms that comes to me when this problem started. The mental illness comes with some very difficult symptoms and sometimes too the symptoms are many and too different, so that why when you feel relief from these symptoms you call it recovery from mental health problems (Ekiti 29)*

The following comment also demonstrates that the concept of recovery as getting better is depicted by a relief from illness symptoms brought on by onset of schizophrenia:

*With the onset of this mental illness that is schizophrenia comes problem, but with recovery also comes a relief from the problems that the mental illness have brought on the person. I don't think that all of the symptoms can go at once. But some of them can begin to leave you and you feel you are getting better because this absence of the symptoms (Delta 37).*

As Anambra and Jigawa argues recovery:

*Means that being symptoms free. You being not to feel any more symptoms, I mean recovery is being symptoms free. There is not too much thinking. I am not thinking as before, and the improvement I have is that before I used to dream and have dreaming, headache, all these complaints which make me not to sleep but which I now free. But now like I say recovery is symptoms free so that I can be able to sleep very well and not like I have all those symptoms before, it has been reduced (Anambra 37).*

*Recovery is like I saw some changes in what I was doing before. There are some changes to what is happening to me and my symptoms like reduce. You know when you have these symptoms like I used to wander everywhere but with getting better you now see that these symptoms can reduce. Like wandering out of my house, I am not wandering again, as I am staying in my house now (Jigawa 30).*

As one health professionals in this study similarly suggests, a good approach to understanding the outcome of schizophrenia is the disappearance or resolution of symptom. From this perspective, which echoes the views of the participants in this study, if a patient who has had schizophrenia no longer has symptoms, then they are getting better.

*For many of the patients we see, they present with behavioural difficulties, evident in symptoms, but with the interventions, during these acute phase there is a resolution of symptoms. In psychiatry sometimes a lasting resolution of symptoms is possible and this is known as remission, where symptoms disappear (Health professional, Dutse 30-34).*

This concept of recovery referring to symptom relief is representative of what Slade (2013) referred to as “clinical recovery”. This concept represents part of a wider move in the medical sector, epitomised by western biomedical practice. The idea implicit in this view is that “mental illness” is a physical disease, and with recovery a person is cured and returns to a former state of health. Thus, primacy is given to the efficacy of medication in determining psychiatric outcomes.

However, another feature of this concept, was the idea of recovery as being the opposite of illness. In this way it is also conceived as central to functionality. As Ondo observes:

*As I am getting better in this recovery and with my symptoms going then I can be able to be doing some things for myself. It really disturb me that some of these things I cannot do for myself but like I say I am getting better. I think that it is good. When the symptoms leave you then you can begin to do many things. Some of the things you want to do myself then you can begin to be doing it, because you do not longer feel too much overwhelmed or because the symptoms are kind of pulling you down (Ondo 36).*

Some of the men explained that they began to develop ways to (re)engage in daily activities of life with symptom relief making much needed room for increased functionality, as Nasarawa notes:

*It is good for the symptoms in which you are experiencing to go away. One thing is that the symptoms can leave you and you can feel better in yourself. The reasons that you feel better is that you do not feel disturbed and too concerned about your condition any more as this kind of problem say you no longer see those spirits that are affecting you and making you not to stay in one place, then you can say that you feel relief from your conditions. The importance of this relief is that you can be able to do more types of activities for yourself. Before when these conditions was affecting me it was difficult for me to sit down in one place, so it was not easy for me to go the village meetings. But now you see with this relief it is possible for me to start functioning in the community again (Nasarawa 27).*

This wish to return to the former, functioning, self, following symptom relief is understandable, and is a so-called restitution narrative (Frank, 1995). The restitution narrative is a story that some people tell about their recovery. Its basic storyline is: “Yesterday I was healthy, today I am sick, but tomorrow I will be healthy again”. The phrases “good as new” and “I feel like myself again” capture the essence of the restitution narrative. However, such a linear model was not reaffirmed by all participants in this study, instead some talked about an alternative explanatory model regarding a non-linear process that involves making progress, losing ground, and pressing forward again.

*In this conditions that we are facing it is difficult to say that you can just get better in one straight line. It my case, it is not like it is a straight line for recovery to get better. The reason is that these symptoms that are disturbing you can come back. And when these kinds of conditions or problems come back then you can go back to square one. This is because the symptoms have come back and you begin to feel bad again, as it happened to you in the first. So these symptoms begin to affect you again and you have to go back to the hospital and stay for sometimes, just like the first time that you think that you are okay. So it is like this kind of illness is up and down because you can feel better today but who knows because tomorrow you can get back those symptoms (Cross River 28).*

What the data seem to reflect is that the recovery journey is not made up of specific succession of stages or accomplishment, it does not follow a straight course. Instead recovery can be linked to a process, one that sometimes spirals back, and may result in a frustrating return to illness.

As Baylesa and Gombe explains:

*When the symptoms started like I was hearing voices and doing all these types of behaviour that some people say was not good or was bad. I know it was not good behaviour because it was affecting me and it was not possible for me to do anything for myself or for my family. But after a while the conditions change and I was feeling better with myself. The problem is that after another time this condition changed again and the symptoms like come back to me all over (Baylesa 34)*

*All of sudden the symptoms reoccur. The problems of my mental illness started all over again. It is like one moment I was getting better from all of the mental illness symptoms, and feeling that I was in recovery, but suddenly the symptoms that I was having before came all over me. To me one minute you can be better but the next minute the mental illness can come all over you again (Gombe 23).*

This is representative of the views also expressed by Deegan (1988), where recovery was likened to a process, a way of life, an attitude, and a way of approaching the day's challenges, which is not perfectly linear. This is because at times the course is erratic and people falter, slide back, but can re-group and start again. Therefore, as the men's experiences show, recovery can involve setbacks resulting into symptoms reoccurrence as well as perceived progress in symptom relief and functioning. As Haro et al. (2014) suggests among psychiatric patients achieving symptomatic remission in schizophrenia is associated with an increase in their quality of life. In many cases patients in symptomatic remission had better social functioning (such as measured with the frequency of having paid employment) than patients not achieving symptomatic remission. Whilst in that study there was an emphasis on the psychosocial functioning after clinical remission, it does also highlight the difficulty of mental health recovery as symptoms reoccur.

Alongside data which highlights recovery from mental health difficulties as involving symptoms relief, there was evidence suggesting that a return to expected (gendered) societal roles is also recovery outcome and this will be discussed next.

### 7.2.3 Expected roles return in recovery

As data from this study suggest, getting better (recovery) can be said to take place when expected roles return. In this way, the evidence suggests that recovery is not only about symptom relief, rather, recovery is also strongly linked to the reestablishment of ascribed roles:

*When the expected roles return that is recovery. The problem is that the mental illness disrupt the roles that you are supposed to be performing. In your daily life there are some things that are required to do, but you cannot do all of these things because the sickness had taken over you. That is why I say that when you begin to do the kind of roles that you think is important for you then you can say that recovery is taking place for you (Lafia 32)*

*It is about being able to function again from the mental health problems that you were facing. When you bring back yourself together you begin to function again in those areas like you were doing before. There are some areas or roles that one is expected to do so with recovery you can see that these roles being to return. As I talk to you I am beginning to function in some of these roles (Katsina 27)*

Recovery from this perspective becomes integrally linked to functionality such that loss of function denotes absence of recovery, whilst performance of roles connotes recovery. Andresen Oates and Caputi (2003) similarly argue that recovery implies active involvement in roles, either by regaining roles that were lost through the severity of the illness or in the creation of new roles.

As findings here suggest, the ability to work, the participation in meaningful activity such as employment, is an important indicator of positive functioning.

*My own view, I would say recovery is returning to your expected roles, like started to work again. You see when this illness started you are lost and but now you return to work, that you needed so much. This situation that has been lost, so bad for you, and to help you face situation that has been lost. But for you return to work, that is what I really understand about recovery (Kogi 31).*

For another man, employed as a teacher, his ability to function again and teach his pupils was evidence of the emergence of his recovery.

*I was able to return to my professional role within the classroom to teach my pupils. As a school teacher, schizophrenia disrupt my professional abilities to teaching because all of these symptoms were over me and you cannot function as a teacher. The important thing about my recovery is that I re-started to teach again as I used to do previously as a teacher who has to be able to play his role with his recovery (Kano 39)*



Similarly, a return to education is seen as demonstrating recovery from his mental health problem for Lagos.

*The road to recovery can make us with mental health problems to return to our studies. When my studies was stopped I was experiencing this mental health problem and was not happy because I could not continue with my education. But with recovery you can get better and one of the biggest things I've had to accept is that recovery from my condition has helped to function again with my studies (Lagos 22)*

Another man, a trader, associates his restarting to wake up early and being able to reopen his shop as evidence of getting better. An important outcome of recovery for Borno was his reengaging with his business venture.

*My business is very important to me, but this collapsed when the illness descended on me, so the shop has to close down. It was being able to open my shop again that I call recovery. My shop was the business that I am doing to earn money but this closed down and I was not able to run it when the symptoms of this schizophrenia. Like I said it about getting back to the business that you were running before one fell ill (Borno 28)*

Being able to return to roles around employment and work were tied to roles of headship of the family and seen as indications of positive functioning.

*As a man it is true that when he has got his recovery he will be able to get his positions in the family back. That is when the man has recovery and able to be back to his positions then he can be able to perform his role as the head of the family (Kebbi 24)*

*In our communities it is important for us to function as the man that has some responsibilities. What I mean is that a man's position in our community is that he is the head of the house, therefore it is very important for him to be able to get better to be able to meet with these responsibilities that he has to do in his family (Ebonyi 40).*

Thus return to the position of being head of the family was certainly seen as a signifier of recovery. In this way, recovery embraces other aspects of life that are not limited to the relief of symptoms, but which include a restoration of the various domains most men felt were important such as a job, accommodation, and engagement with community (Onken, et al., 2007). With regard to the primacy of being employed, Bouwmans et al. (2015) suggest that employment plays a central role in providing financial income and a sense of personal achievement in people with schizophrenia. Additionally, their study showed that employment is correlated with positive outcomes in symptom levels and in functioning.

The findings of the current study highlight recovery as getting better involving relief of symptoms associated with the mental health difficulties. However, the data also highlight alternatives to this more medical view of recovery. Much of the evidence in this regard focuses on the restoration of valued social roles.

*Recovery in schizophrenia is actually a term full of controversy, but broadly speaking, we say recovery is achieved when the symptoms which impair with the functioning of the patients have disappeared. So when the symptoms affect him and these symptoms disappear then we think that recovery is in progress. Also, when these symptoms disappear and his formal functions such as he has started to work again, and then we can say that recovery is in progress. Essentially, when the personal function is returned, then we can say that recovery is in progress. For example, occupation has returned (Health professional, Yola 25-29)*

This is also reflected in the following comment by one of the men interviewed:

*It was being able to live in the community again, to do those activities that one values to do. In doing so I think one has re-establish in those areas that were disrupted when the mental illness started. That means being in recovery involves there is a change from a disruptive situation when the problems started to one in which you begin to feel better and this includes returning to your job and making the contributions to their household (Ondo 36)*

The hegemonic defining of masculinity through bodily function (Connell 1995), through “doing”, makes this linking of recovery with functionality commonplace for many men in current study. It demonstrates that ideas about recovery are mediated through ideas about one’s gendered identity and, for these men, this usually entails the linking of recovery to the medium of action with the ability to function claiming paramount importance.

Given the foregoing discussion, there were multiplicity of views about the meaning of recovery, while some believe it to be getting better, the relief of symptoms, was also a clear sign of recovery. Yet some participants linked recovery with return to societal roles. Having explored the data, which highlights the definitions of recovery, I will now consider the factors that influence men’s recovery in this community in northern Nigeria.

## 7.3 Factors influencing men's recovery from schizophrenia

As indicated earlier, participants' understanding of recovery involved the notion of getting better. This includes relief from symptoms and reestablishment of prior employment and household expectations. The data revealed influences on recovery from the mental health difficulty and this will now be discussed.

### 7.3.1 Western medicine

When some of the men talked about their hospitalisation and how the commencement of western medicine facilitated or impeded recovery, there were mixed views about the role of western psychiatry. They explained how the inpatient admission provided them with a place of safety, and this sanctuary was viewed as a turning point in their recovery.

*At that time I was not myself. But my family say that I was behaving like a person doing something like a person with mental illness and sleeping in the streets. But when I came to hospital I felt better because they started to help me to calm and as you know I remain in the hospital (Kwara 42).*

*My situation could have become worst because every day, when you hear all these voices in your head, it kind of makes you want to do things. In some ways it took me out of a bad situation. I don't know where I would have ended up if I did been left with what I was doing with all those voices talking me things, which I could have regretted doing (Imo 28).*

This view is also reflected in comments by the health professionals.

*Acute episode of schizophrenia can present with behavioural disturbance, where with the onset of the illness the patient will be at risk to himself and members of the public. With this type of positive symptoms, the patient might not be able to know right from wrong hence the risks of harm to the self or the public is significantly high during this episode. In this situation it is necessary and important to secure the safety of the individual or the public by admitting the patient to hospital for medical care (Health professional, Sokoto 40-44).*

As Atilola and Olayiwola (2010) suggest, for people with schizophrenia, hospitalisation was seen as helpful for the management of acute symptoms, which could otherwise place the individual at risk of self-harm or harm to others.

The evidence from the men further narrated how assurances from healthcare professionals were also indicative of hospital as a place of safety. As Olusina, Ohaeri and Olatawura (2002) revealed, psychiatric patients place the highest emphasis on staff's empathic qualities and there is some support for this feeling about medical staff in Nigeria when Bauchi comments:

*In the hospital the doctor was nice to me. He used to talk to morning, say like every morning he will be coming to talk to me. What I am trying to say is that every morning I feel that the doctor has talked nice to me and make me feel nice too. For example, when he comes to the hospital he says to me, and asks me "my friend, how are you today?" And he also being nice to me as he says I will be fine (Bauchi 27)*

These, and similar accounts, suggest that hospitalisation represented a key phase in resolution of mental health problems for these men. However, the findings of this study also highlight difficulties associated with inpatient services. For example, Gombe's concern was that people wandering around the ward made it unsafe:

*I kind of felt unsafe being in there, you know with everybody wandering around. People will be around and you don't feel safe. When you see some people who don't even know who they are and you don't really know because then it makes you to feel unsafe. Some of people they also admit, you know about them, so that also makes me kind of feel not safe (Gombe 23)*

Ekiti talked about the noisy environment:

*When you're not well you need a relaxing environment, and I would say that the in-hospitals really is not a relaxing. And when people would come into hospital, they would think that they can relax, but it is not always so. My doctor told me to come in here to have a rest, but, I am not able to get a rest. It was too noisy. It was not a restful place at all to me (Ekiti 29)*

In these instances, according to Delta getting enough sleep was difficult:

*To sleep is the problem. To me to sleep in this noise is difficult for me. When you close your eyes and trying to sleep you will just hear bang and that noise can keep you from sleeping. Till day break I cannot sleep in this kind of environment because it is noise that keeps me awake. It is difficult to sleep under this condition. And sometimes when I do not sleep because of all of this noise, I do not feel well. Man needs to sleep and rest, but if you do not sleep you will not feel you have enough rest and that can affect your health (Delta 37).*

Cross River reports that basic amenities such as electricity and water were in short supply:

*We don't receive proper care in this hospital, my brother. As you can see electricity is gone off and it may not come back until tomorrow, water too is problem, as you can see again, my brother there is no water to flush the toilet sometimes even any water to drink at this hospital. My brother, I have not finished talking to you, sometimes we stay in darkness for plenty days without light or water. You see, the ward is also dirty and there is rubbish everywhere (Cross River 28).*

Ebonyi raises concerns that lack of water and electricity affected his personal hygiene:

*To have bathing under this condition is hard. For many days now there is no water and we are just staying without bathing. How are you going to bath when there is hardly water in the ward? You see even to wash my clothes is a problem, because there will be no water to use. The problem with this not bathing is that I get dirty and for sometimes I will be very dirty but cannot take bath. But when I am dirty I do not feel okay. Even when I do not have clean clothes to wear I too feel bad. So it is concerning me about this lack of electric and water (Ebonyi 40).*

The results presented here then ascribe importance of hospitalisation in both positive and negative ways. On the one hand, the ward environment or the inpatient admission represented a key stage in dealing with their problem generating feelings of safety and security and representing a significant turning point towards their recovery. However, some, also referred to their hospitalisation as not particularly therapeutic because of the inadequate or poor hospital amenities that were cited as affecting their mental health.

Apart from hospitalisation, data from this study further illustrate how medication was viewed as an essential part of western biomedical care. In clarifying further how this approach was useful, the data also bring to light the importance of contact with healthcare professionals and particularly the conveying of useful information.

*There are some steps which my doctor gives me to follow and if I follow them I will see some changes. I normally see changes when I follow the steps that the doctor has asked me to follow. They are like simple instructions of the doctor, but if you take them like obeying the rules then you will be able to get full recovery (Kebbi 24).*

*By the time you are not behaving well, sometimes you were seen roaming in the street. When you are roaming in the streets like that the hospital is a very good place to be. It is safer for you to be in the hospital. In the hospital, they can also take care of you. In my own case, they give me some medications to calm me down (Gombe 23).*

This view is similarly reflected in the comment by Benue:

*Yes, when I came here to the hospital, the doctor prescribed the medication for me to go and buy and when I out to the town I bought the mediations and I started taking the medications according to what the doctor say. As he is my doctor you know he can tell you the medicine to take (Benue 30).*

As Lacro et al. (2002) suggest medication can play a significant role in participants experiences of recovering from mental health problems and this is reflected in the following comment by Adamawa:

*Well to some extent, I can say that the drugs I am taking now have helped me in recovery. I think they have helped me. They are helping, even though I am not 100% myself. But the drugs have helped and I can say that I am 60% myself. So, I think this prescription from the doctor is necessary. It is good to be able to get this prescription, as I think it is helping in my condition (Adamawa 30).*

Ekiti, similarly reports that he took medicines because it helped with symptoms relief:

*What is making me to recover is the drug that they give me. The doctor in the hospital gave me some medicine and when I take it, it is helping me. I can say that it is helping me to sleep because if I want to lie down to sleep than I can take my medicine and it helps to make me sleep. If I take the drugs I will just go and lay down to sleep. When day break, I would get better I would stand up. I would sleep well and I would stand up. That is the only thing I say that medication is important (Ekiti 29).*

The main thrust of this is that some participants believe and rely upon treatment with medication because of their biological beliefs about schizophrenia. This might be the idea behind Adewuya et al. (2009) finding that medication-adherent individuals had significantly lower total scores on the psychiatric rating compared to those who were non-adherent with their medication. Again, this association of western drug medication and improvement in symptoms was echoed in the comments of Imo:

*According to the doctor, medication is there to relax you. It is there to relax your mind, so that you will not have the feelings again. This is true because when I take the medication it helps me. Because taking the medication it helps me to relax. But I can say with time that I was taking the medication it will help to overcome it. So when I was taking the medication it helped me to overcome this problem and I was able to relax (Imo 28)*

The accounts of the participants' also implied that stopping medication usage may herald the recurrence or worsening of symptoms. It was in this context, that apart from relief of symptoms, western medicine was also cited as important for relapse prevention.

Niger highlights the importance of taking his medication to prevent relapse:

*Medication, like what I said earlier if you taking the drugs then you will be okay. You are taking it on a daily basis as prescribed by the doctor you will have no problem. Because, I can see from my own experience that when I am taking the drugs I will not have any of these feelings. But by the time I think that I am okay and stop taking the drugs by the time, the symptoms will come. Then the sickness will relapse, it will reoccur again. So, it is better you take the actual dose the doctor has prescribed for you. I say it is better to keep taking this drug because it will prevent you from relapse (Niger 38).*

Kano likewise realises how essential his medication is:

*The drugs help me to keep me in control, because I remember that I stopped taking the drugs for about a week and there was a relapse (Kano 39).*

Similar arguments associating failure to adhere to prescribed antipsychotic medications with a higher risk of relapse and rehospitalisation were made by Adelufosi et al. (2012). The implication of this for health practitioners is that these individuals need to be encouraged to take their medication.

Important though the place of western medicine is in facilitating relief of symptoms and prevention of relapse, the data I wish to consider next relates to why do some of the men stop taking their antipsychotic medication when there is some evidence that doing so often leads to unfavourable outcomes? From the data, there is no single reason for this, however, side effects, and costs associated with western medicine were often cited.

*It is true that medication from the doctor was helping me with all of the symptoms that was causing me disturbance. It helped me very much and it was like for some time one can be okay and became fine, like one can say that all of those demons have gone and one can feel relaxed and rest every well. But again after few time, it was the same medicine was causing some other problems. The problem you do not have before can now be brought on by these medication you are taking. Like after something when you take this medication you can begin to feel weak, but before you were not (Osun 40)*

As Liberman (2012) reveals while antipsychotic medication is the primary treatment for acute episodes of psychosis, the first experience that patients have with medication is almost invariably an adverse side effect. Thus, although anti-psychotic drugs are a useful resource in the management of schizophrenia, these drugs are frequently reported to have side effects. This position is summed up in the following comment by Bayelsa:

*I have already said one aspect of it, the other aspect is medicine. I am not against medical. The only problem I have with medicine is the slow pace it takes to work and the drugs that I have been on, I take them every day, sometimes the side effects will show, and then I take another drug to counter the side effects and continue like that. So, medicine is use of the number one things, it is not exactly the number one (Bayelsa 34).*

For example, Ondo suggests that the drug he was taking was a likely reason for his hand shaking.

*I receive treatment, but my hand is shaking. That is my problem because as soon as I take this medicine then I stay for small time then my hand begin to shake. This makes me not to be stable with my body, because as my hand is shaking I am not stay one minute in peace without shaking (Ondo 36).*

One implication of this according to Edo is that this shaking of his hand was affecting his performance at work because of his inability to remain still or concentrate:

*The medication is now a thing that it causing me some problems. My hand is shaking and it is difficult to hold a biro. That is the problem that the medication is now causing, because my hand is shaking it is not easy to hold a biro to write. It is not easy to hold a biro at all with this hand that is shaking. That is the main problem that is affecting me at work because once your hand is shaking it is not possible to write (Edo 45).*

Similar arguments are made by Elble (2009) when they suggest that side effects such as shaking or tremor of the hands referred to in this study most often involves small, rapid movements occurring more than five times a second. This unintentional rhythmic movement of the body is typically associated as a side effect of medications for schizophrenia. The additional, related problem is that one may feel intensely restless and unable to sit still. In such circumstance, this can interfere with daily activities, as individuals may have difficulty holding or using small objects such as a pen and have problems with writing.



Another side effect talked about from taking medication was sexual dysfunction. This is exemplified here by the following comment by Ebonyi:

*It is a big problem, like one can say that having sex was a big problem. When you take this medication it knocks out sex because having erection is a big problem. It makes it that the erection is not there and when erection is not there it is difficult to have sex. The doctor kind of knows and he changed the medication, but even these new medicines still make me not to have erection. It is not getting up and feel limp without standing up, and this is a problem if it not standing up because of the medicine that is affecting it not to get. What would one do, if these kinds of medicine are affecting his family life, then he has to stop taking it because family life is affected (Ebonyi 40)*

Diaz and Close (2010) suggest that, some medicines for schizophrenia have an effect on the blood vessels in the penis. Other medications that act on the brain or interfere with hormone levels (particularly testosterone), or affect the transmission of nerve messages, can also cause impotence. Anti-psychotic medication, risperidone, for example, although mainly used for treatment of schizophrenia is more likely to result in sexual problems as well (Diaz and Close, 2010).

One implication of this is that some of the men in this study rather than not being able to perform sexually, would rather stop taking such medication. This is not unexpected as in traditional Nigerian societies sexual potency is important and males are expected to have sex with wives to raise children.

Delta's comments demonstrates this:

*In this our society it is important for us to have children. That is our family life, children are our family life. So when we take this medication and it begins to affect us then we have to stop taking the medication. Of course, we have to stop taking this medication as if one continues to take it then it will be difficult to have children. Especially, when we take this medicine that we get from the hospital it affects us not to have sex and this is a big problem, like one can say that having sex was a big problem (Delta 37).*

*It will is difficult to continue taking this medicines because it cause you problems. The side effects cause you not to have erection. This is a big problem, because you are not able to have children with your family. What will you do when you are not able to have children? Then you have to leave the medication (Ebonyi 40).*

Although it has been shown that individuals with schizophrenia in this African setting can experience side-effects to antipsychotics (like their counterparts in western culture), within the mental health recovery literature, it is unclear why these side effects persist in some individuals. The findings of this study offer some insights pointing toward the difficulty psychiatrists have in finding the right type of medication and also the right dosage in order to prevent side effects was reported by Adamawa:

*I don't think the hospital people themselves know all the correct drugs. They keep changing, changing and changing drugs. Last time I take the drugs and they are harming me. Before the drugs were harming me. Some months ago, they change the drugs, but now I have a feeling the drugs are much better (Adamawa 30).*

Kano similarly says:

*It is like they try one and try another one. And then they try that one again. It is like starting all over from beginning to try and explain to the doctor about the problem with the medication he has given you, then that medication you start to take now has another problem for you and then you tell him. So, it is like try and see, then it is like try another one to see (Kano 39).*

While the use of medications may be associated with symptom relief, it has also been found that the process of prescription might need a series of trials to find the right medication and the right dosage and the psychiatrists' process of trying a series of medications until the current point of relative satisfaction was typical (Velligan, et al. 2003). But this often forms an obstacle for service users who are reluctant to cooperate due to the string of side-effects from western medicine highlighted by data in this current study.

The evidence of side effects presented in this study and associated to western medicine suggests a crucial dilemma. That is a possible explanation for why most of the men in this study hold strong convictions that it is better not to take these medications, even where it has been shown to avoid symptom exacerbation or recurrence of symptoms. However, side effects from

medication use is not the only predicament, the costs of medication was also a big issue. As Kaduna says:

*Take for example I am to pay for this drugs for which the doctor just write. The doctor just wrote some drugs and I have to buy them. I think for medication four weeks that is I bought for the last time it cost about three thousand naira. And he has just written for sixteen weeks. So it is going to cost me money and what will I do not have money to buy the drugs, I might have to stop taking them (Kaduna 30).*

In Nigeria, an assessment of the financial costs of drug medication (Effiong and Umoh, 2015, Meshach et al., 2014, Osahon et al., 2016) showed that the costs of purchasing these medications from hospitals are a challenge to many of the service users. The view of Cross River reflects this:

*I don't really know it is like you need to take the medicine and treatment that the doctor has said you should, but it is hard, because the cost of this prescription is too high. But what am I going to do because if they say something is good then you need to have. It is not like I do not want to have the medicine but they cost is high (Cross River 28).*

This problem is exacerbated by poor living conditions. Enugu mentions that his income is meagre and even though there are associated benefits with these medications, having enough money to purchase doctors' prescriptions was often problematic:

*The cost of the medicine is high. I really mean it cost too high and the money to pay for it is the problem. See me my own case for example, I take some salary from the small work I am doing but even say I will have to use all of my salary to pay for the medicine it is not even enough. I say it is not even enough because the doctor has said you should, take this medicine and when you go out to try and buy but you find that the costs of them are too high (Enugu 42).*

As Adewuya and Makanjuola (2010) found, of the 99 outpatients recruited in a Nigerian study which explored their living conditions, many earned a monthly income of less than five thousand Nigerian naira or about forty United States dollars per month. The other problem is that more than half of such earnings was spent on medication, between two thousand to five thousand Nigeria naira monthly on psychiatric medications as documented in another Nigerian study (Adewuya, et al., 2009).

One of the issues emerging from this relates to borrowing and begging to pay for services in most of these hospitals that provide care on a fee-for-service basis. As Adewuya et al. (2009) noted, there is no Government subsidy for medications, thus making the cost of treatment a burden largely borne by individuals and family members. Therefore, these male service users who have to make frequent payments for hospital services find that they often have to rely on significant others such as relatives and friends to help them.

*This last time I borrowed to come and sometimes I beg from people to get money to pay for the medicine. In a month I use to spend at times over N16000 ...I am not able to afford this because my money is not enough and you see the medicine is very expensive so that is why (Kogi 31)*

As indicated, with the onset of mental health difficulties, it is important to draw upon resources such as western medicine. However, one of the other difficulties spoken about was that a majority of these western bio-medical care is mainly located in cities. The difficulty then is that accessing such services can be problematic for rural dwellers.

As Lagos says:

*The hospital is far there in the town. It is not easy to get to because the distance is too far. I can tell you that in this place there is no hospital near here. Even if you see you want to go to the hospital then you have to go to another town different from where you live, because where you live there is s not one psychiatry hospital and you have to go from one of this your own place to the other place to go their hospital as you do not have one near you (Lagos 22).*

A similar situation was noted in Jack-Ide et al.'s (2013) study where they observed that many western bio-medical services in Nigeria are located in the state's capital or larger urban centres, adversely affecting persons living outside the city. One of the issues emerging was that some service users were having to travel long distances to access such services, with some individuals travelling over an average of one hundred and twenty-two kilometres to reach the nearest psychiatric hospital (Amoo and Ogunlesi, 2005). The distance travelled to access western medicine is also of great concern for family carers. Problematically, this long journey to a western bio-medical practice located in a distant urban area could take accompanying

family carers away from their other family responsibilities for a number of days. Jigawa raised these concerns:

*I know today is the clinic, but what we did was come to my sister's house a day before to enable us to come on time for my doctor's appointment. If we are to come on this day we will not meet up, even if we did we would be the last to leave and we would not be able to go back, so we normally come the previous evening and sleep overnight to be able to keep this appointment (Jigawa 30).*

Nasarawa, complained that accessing western medicine located in cities needed some pre-arrangements but this was particularly difficult to achieve during times of crisis caused by their illness that required prompt interventions.

*To be able to go to these their hospitals in the town, you need to make arrangements before, what I mean by arrangement is that for example if somebody has to go with you, then the family need to make arrangement so that you can be able to go the psychiatry in the town. But sometimes what I want you to know is that this kind of our illness can come on just like that. I mean for example in case of say emergence when it comes to you, then how will you go to the hospital that is far in town is real problem (Nasarawa 27).*

An implication here is that some people do not receive the early western bio-medical care that is reported to facilitate improvements, but instead receive later treatment having been taken to the nearest alternative place offering treatment. One man explains how initial contact was made with a near-by village prayer home, during illness crisis, when he could not immediately be taken for western medicine. Borno says:

*I think at that time it was too far for me to go to the hospital in town. The reason why I say it was too far is because the other hospital is far in town, and as this thing come on me during that time, I think that it was like where is the nearest place to take me too. As I was not myself that time and this illness at that time was not making me to doing well, but doing something out of control. Like say I had mental illness and walking everywhere in the streets (Borno 28).*

As Zamfara a health professional explains:

*In fairness to the patient, the majority of the psychiatric hospitals that we have in our country is located in the state capitals and this can be a distance to get to from the rural communities. With some of the patients that need to be attended to, you find that the distance to for them to come us in the hospital is a problem (Health professional, Zamfara 35-39).*

The difficulties of accessing western bio-medical care was highlighted in another Nigerian study, which found that the majority of those diagnosed as having a mental health issues in the previous twelve months had not received treatment (Gureje and Lasebikan, 2006). Thus with the largely urban hospital-based nature of western medicine in Nigeria, it is understandable the loss of individuals' to alternative treatment practitioners (traditional and religious sources) who are relatively greater in number, more widely spread, and hence more accessible in contrast to western medicine located further away.

Consequently, the view is that more could be done to make the difficulties of accessing distant urban hospitals for western medicine less problematic.

*Like if we can have a nearby hospital then it will be good. If they can help us with one hospital near us then it will be better. When that hospital is too far to go is a problem for everybody. But like if we can have a place to go to that is not very far especially then it will be very good (Abia 29).*

*The hospital is not in our village, but far in the town. It is not easy to travel because it is very far. All of the doctors that will attend to you if you need psychiatric are in the town and none of them is in the village. That is one big problem that we are facing. Because some of us don't know what to do because of the far distance. If the government can help us to build more hospital near the village, it will be better (Lagos 22).*

This is representative of some of the wider challenges facing mental healthcare in Nigeria. Although the establishment of western bio-medical services in the country might do well to aid Nigerians living in urban areas, the national policy on mental health (Federal Ministry of Health, 1991) is hinged on the integration of western medicine into rural areas, using primary health care as the vehicle. Nonetheless, it seems progress needs to be continued. If mental health service is made available in rural primary health centres, it will help rural residents.

A range of views were expressed regarding medication, most considering it an essential part of western bio-medical care that should not stand alone. Overall, participants did widely endorse their subjective sense of the critical role of western medicine in contributing to improvements in symptoms and the prevention of relapse or recurrence. Indeed, it seems that western medicines subjectively occupied a prominent role in the incremental process of recovery for the men interviewed. Important though the place of medication is, nonetheless, there were concerns about side-effects attributed to psychiatrists' difficulty in prescribing the right medication. Participants also highlighted the cost of medicine as affecting medicinal adherence. Despite these mainly positive views of medication, difficulty in accessing distant western medicine in state capitals or urban towns hindered their utilisation.

It is in light of these concerns that some participants' articulated possible solutions to the underdeveloped use of western bio-medical care in Nigeria. Their comments indicate that a significant challenge to western medicine is the low priority of mental healthcare on Government policy agendas.

*Well I went to hospital but mental illness is low priority for them. I do not think that they really care about mental health. That is what I can say that they do not consider mental illness or wish that mental health can be good for those of us who has mental illness. So, it is low priority to them. It is a big challenge for us because the Government is considering it to be of low priority (Bayelsa 34).*

This concern is also expressed in the comments of a male service user who maintained that the difficulties experienced at Nigerian western bio-medical services are attributable to low funds.

*They are not looking after us patients' properly so they only put small money to psychiatry because they say our mental illness is not their priority. Like they say cholera or heart attack can kill people immediately so that is the more emergency to the government. But our government put small money for electricity, even small money for water so that is the reason we think because the government does not consider psychiatry (Anambra 37).*

Osun, another participant, points out that more could be done to make the experience of western bio-medical care better.

*I think it is important that the Government put more money into psychiatry. The reason I say this is that the staff in the hospital can use this money to provide some of what we need in the hospital. If there is more money, I think some of the things that we do not have can be made to work. With this money, they can provide electric and water and we can be able to feel better and we can be able to do take care of ourselves more the time that we come to the hospital (Osun 40).*

As Gureje et al. (2007) suggest, some of the western bio-medical services do not have adequate external support. In particular, some state hospitals are semi-autonomous, in the sense that the hospital is self-sustained by what service users' pay for daily running costs, while the federal government is responsible for staff salaries. The World Health Organisation (2006) also report on the status of mental health service in Nigeria, suggesting there is considerable neglect of mental health issues in the country. In particular, the existing mental health policy document in Nigeria was formulated in 1991. It was the first policy addressing mental health issues such as prevention, treatment and rehabilitation. However, since its formulation, it appears no revision has taken place and no formal assessment of how much it has been implemented has been conducted by policy makers. In addition to these concerns, it seems that although a list of essential medicines exists, they are not always available at the health centres. Furthermore, the World Health Organisation (2006) reported that no desk exists in the ministries at any level for mental health issues and only a small amount of government expenditure on health is earmarked specifically for mental health.

Western medicine then was found to be influential in how the men were managing their recovery, however, as will be discussed further, there are alternatives to the sole reliance on this medical model.



### 7.3.2 Religion and traditional sources

Findings from this study highlight the significance of religion in recovery from mental illness.

In particular, this is premised on the idea of God as an anchor and a healer. In other words, these participants were expressing powerlessness or inability, where in anchoring in God they sought his favour to help them get better. Therefore, the data suggest that many of the men in this study endowed the agency of their recovery to God.

As Nasarawa says:

*Everything is from God and religion in God is the anchor. When you have this anchor then you can say that religion is something nice to you. My religion is nice to me I can say because you have to think one day let this good things with my religion to help me. So I believe in God and I believe in my religion and will continue to do my things that can help through my religion (Nasarawa 27).*

Akwa Ibom explains that:

*You know you have to believe in God. You are a person who in prayer to God. Prayer to God as you have entered into this illness and I know God will help you to solve this problem. There is every power that your prayer can actually help you. It has the power to solve your problems. You believe actually everything from God. If you enter this problem then you can pray and God will help you solve your problem (Akwa Ibom 30).*

As Pargament (2001) suggests religion is one of the first resources people turn to when faced with mental illness. Similar findings have been reported in other countries. In a study comparing European patients with psychosis to a non-psychiatric control group, the psychiatric patients reported a larger number of religious beliefs and practices that offered comfort during times of stress (Neeleman and Lewis, 1994).

No single explanation is likely to offer a complete understanding of a process as complex as religion in Nigerian communities. However, a key theorist, Pargament (2001) has likened this type of religious coping to a “deferring approach”. Underlying this was the suggestion that individuals can take a relatively passive role in the resolution of problems, trusting God to fully resolve the problem without their intervention. This could be what Pargament (2001) meant

when he suggested that the deferring approach can be premised on “God will take care of everything, so there is no need to worry” (p.84).

In view of this, the data indicates how God’s favour was sought through prayer, so that recovery could be achieved. God listens to the prayer, and may or may not choose to answer in the way that some of these men ask of God’s favour. As Lagos says:

*It is good to pray. Because you pray to God to help you, so you can pray so many times and God can now say he has been praying so can answer your prayers. I will be begging God to answer my prayer, so that I can get myself better. Prayers are very important. It is good to pray (Lagos 22).*

Gombe in pleading for God’s help says:

*My mental illness is a stubborn one and so I use my religion to help me get better. You see the first I do in the morning when I woke up is to pray to God, I pray to God to help in this sickness because I know it is only God answering my prayer that can help him. I also have a Bible, and I read my Bible every time (Gombe 23).*

The individual prayer described above is not the sole approach to God for healing. It is worth mentioning that apart from the men craving God’s healing, some also described their use of prayer groups. These groups, formed mostly within Christian congregations but occasionally among Muslim groups as well, gather outside of the congregation's regular worship service to pray for perceived needs. Many of these prayer group meetings are held according to a regular schedule, usually once a week. However, extraordinary events, such as mental illness spawned a number of improvised prayer group meetings.

For example, Ondo talks about prayer group meeting with his church pastor:

*My pastor will pray for me. He will be praying for me, that is why I said that the prayer is good, because when I was in the church they keep praying for me especially so that anyone who does not mean well for me will be rooted out because of that person is not good. Anything they are not supposed to do for me should be back to sender (Ondo 36).*

The data from this study further indicates how the belief that private or group prayer or worship may produce forgiveness with preventive or therapeutic benefit. The significance relates to how some of the men believed that God had answered their prayers, evident in betterment or relief of symptoms associated with their mental health condition. Ebonyi typifies this as follows:

*The prayer is working. It is kind of working to help with my conditions, religion has helped me to recover speedily, because when I was here, there was a pastor, that was coming to pray for me and I really thank the pastor because anytime he comes, I will feel relieved from anything act I am suffering from, either sickness or what conditions that I have being arguing about (Ebonyi 40).*

In particular, Kano contends that he felt relaxed because God had answered his prayer, helping him overcome spirit afflictions:

*I no longer see the evil spirits. That is why I know that God has answered my prayer. In times like this I always believe God will help me. And it is true that God will listen to your prayers, so that it can help you not to see those kinds of spirits and you can be relaxed. Whatever that is happening God is the consolation. In times like this, I pray to God. I am praying to God. And my pastor is praying for me to, so that those things that are happening to me are stopped (Kano 39).*

This could be representative of what Adewuya and Makanjuola (2009a) mean when they write that in the Nigerian setting many perceive illnesses as resulting from mystical and supernatural forces. In essence, they claim to being afflicted by an offended God or spirit. Thus, assertions of divine healing and notions of being symptom or spiritually disease-free were exemplified in this study.

However, the findings also countered positive views of religion to delineate the specific aspects of religion that may be responsible for its troubling links with poor mental health. For example, Lafia talked about how he has been coping through his religion and praying to God but felt God has not answered him. Evidently, he perceived that there has been no change or improvements in the condition of his mental health difficulties despite religious practices:

*For one week I was in prayers with my pastor. Every day he keeps praying for deliverance from God to answer me and help me but they didn't do anything and there was no change. He prays too much for me but I can say that I did not see any change. As person with this condition with prayers some people say it can help you with the things that are happening to you. Like say maybe the spirits of all those that are disturbing you can go way and you can feel better, but for me I cannot say that there was no change in my conditions (Lafia 32).*

What this suggests is that prayer (religious practice) may relieve a person of the need to take active measures to address issues around them. This potential drawback manifests in extreme forms in such cases as those who rely on prayers instead of seeking medical treatment for their mental health difficulties which later results in conditions worsening. Rivers, a health practitioner made this link and suggested it could be partly responsible for a decline in the men's mental health:

*I think there is one significant aspect which has bothered me in psychiatry. And that has being the role of religious bodies. In this environment we have religious bodies that continue to make claims that are at best difficult to ascertain in respect of recovery of patients. They begin to make claims of curing this illness or that illness and there is practically no evidence for this, but they continue to make claims of curing patients through miraculous means and this usually leads to many patients arriving late at the hospital (Health professional, Rivers 35-39).*

Oyo, another health practitioner also highlights this problem and states that this kind of religious coping practice is unscientific. Problematically, claims of recovery through religious means are said to be difficult to substantiate with individuals known to have reported adverse reactions.

*It is difficult to just say that God can just answer your prayers and everything will be okay. You see when pastor say pray to God and then you keep praying to God for answers then your conditions might get worse. Sometimes it can take time for these prayers to be answered and some of the people can have some kind of adverse effects. Some of the people too are here is like when they are experiencing symptoms of illness, they go to all of these places for prayers, and the pastor will continue to pray for deliverance. But to me it is not easy to substantiate. To me to say symptoms can just go away because your pastor just pray for you is not easy to back up (Health professional, Oyo 35-39).*

Just as data within this study suggests that some of the men make claims of recovery being associated with the power of prayers, there is also evidence that the men also felt that religious texts helped in some sort of spiritual deliverance from mental illness. As Parkin (2007) points out, there is a complex interweaving of medical and religious themes in Islam, and more

specifically in the Koran. In this sense, religious texts as a conduit to God is held by believers of the faith to have healing power.

In this way, Katsina explains that he recites religious texts believing that it can elicit a cure and aid recovery:

*It was when I went there and it was when I was there that I met with the mallam that he now brought out the Koran and he begins to read the places for me. It is like every time he used to read one place for me. I think the reason he said he was reading this particular place is that it has the power to help me of my illness. And that is why it is important to read this particular place so that it can help (Katsina 27).*

Gombe also mentioned that:

*Then I now got close to God, keep on reading my Bible. I just keep on reading my Bible. There are some verses which our God said that it is necessary to read. It is good to be reading the Bible so I came to a point when I was reading my Bible verses so that our father who act in heaven can give us this day as our daily bread and deliver us from evil. That is the importance of reading the Bible, because there are certain verses that they tell you to read and it will be one day when you read it will deliver you from all of your problems (Gombe 23).*

This could be representative of what Syed (2003) meant when he suggested that in Khawass al-Quran the miraculous properties of each passage of the Quran are discussed including the curative properties for various diseases. Thus, a person who continuously recites sufi shaikhs or pir is said to be cured from demonic possession (mental illness). However, concerns were reported too, for example, Taraba one health practitioner notes:

*There are many of the people that have this belief in the words of the Bible or Koran. They just believe that bible verses or some of these places that you can find in the Koran will cure them of their mental illness. They will keep reading one verse always believing they the solution can come from this verse. But you see that is one problem because you cannot just continue to be fixed on reading one verse thinking that it will safe all of your problems. Like this you see some of them when they are reading this verse always they refuse to come to us, to check them to see if there is another solution (Health professional, Taraba 30-34).*

As Adeponle et al. (2007) observed in many towns and cities in Nigeria, it is rare to find a street or two without at least one prayer house or home fellowship. In these towns, announcements of crusades and evangelistic programmes with promises of miracles, healings, and deliverances from various afflictions and sickness are a common occurrence. However,

followers of these prayer houses are challenged to believe in the reality of faith healing, while also being encouraged to refrain from the use of medications.

This has implications, relating to illness outcome as clinical observation strongly indicates that an appreciable number of patients who default on western medicine for faith healing eventually present to out-patients clinics in much worse conditions. These comments by health practitioners reflects these concerns:

*Most of the patients we see have gone to religious homes and arrive later into the hospital. Apart from this when they come to hospital and get better, they go back to religious houses after which the religious homes in a subtle manner or even in an overt way discourage them for taking their drugs saying that they have been healed. In fact this contributes to a large extent to relapse of many of the patients that we see in the hospitals (Health professional, Oyo 35-39).*

*When the mental illness start, they might have different reasons for going for traditional medicines, instead of coming to the hospital. But the problem with this is that for these men that attend these traditional healers, there is no recovery for them and they soon realise these places is not the appropriate place. The point is that there is a delay in their coming to us and often this have contributed to worsen their condition, with many of them coming under emergency treatment, where we notice that their conditions are worse (Health professional, Yola 25-29)*

Mohr et al. (2012) also found that those with religious beliefs also reported more conflict between their religion and western medicine. This also might have implications for recovery, as the more their religion was in conflict with western biomedical care the less likely was their adherence to western medicine.

As indicated, religious beliefs about recovery anchors on God's agency. As one participant in Kinsella, Anderson and Andersen's (1996) study commented "I've always had faith in God that God cared about me. So, I always prayed. I always believed that he would hear me, so I never gave up and that's how I kept going". However, one effect of this approach is the possibility of increased pleading to God in instances where they felt unanswered by God.

This is the idea behind “over-religiousness” exemplified by Sokoto, a health practitioner:

*They became over-religious. There is an increased religious activity. When they have been told to read a particular place in the Bible or the Koran and they have been reading it every day and every day hoping that it will let God to help them. But when there is no such help they will not give up. Some of them continue to read these religious text even more than they used to do before. So we can say that there is increased religious activity. Instead there is what is said to be increased religious activity (Health professional, Sokoto 40-44).*

To amplify these points, the health professionals had considerable case history material to suggest that religious beliefs and practices may be seen as psychiatric symptoms, especially where these were culturally alien, or negated the western biomedical framework. Here are examples from health professional’s comments:

*Some of them have what we call religious delusion. Religious delusions in the sense that they believe that they will be healed even when they have been praying to God before God may not have answered the prayers. Because they have been praying or reading the Bible but there is no improvement in their condition. Even when they come to us they keep holding the Bible saying that when day God will answer. Like the other day one came with Koran saying that he will not give up reading his Koran because he knows that Allah will answer his. You will see those who have this kind of psychotic symptom chanting and intensely reading these verses and when you ask them why, they will say that God is in control, as such they need to approach here. But for us in psychiatry we can call this a delusion (Health professional, Taraba 30-34).*

*With due respect to the patients that we see, there can be a problem with the issue of religious beliefs and the part that religion plays in their mental health problem. Some of these patients hold religious views and it is no wonder that they look onto these religious means for treatment. I am not saying that it is bad for patients to have religious views, but when there is no evidence for this then there can be a problem for us to recognise such beliefs. A patient may have religious beliefs that God is the cause of his illness, but where we do not have evidence for this, this is what we refer to as religious delusion (Health professional, Plateau 35-39)*

Loewenthal and Alan (2011) similarly argued that religious beliefs have been linked to psychiatric delusions. In particular, religious experiences may lead others to view the person as suffering from schizophrenia. Finally, as demonstrated in this study, religious beliefs and practices supported by individuals in one culture may appear as disturbing to others. For example, mental health practitioners could treat such beliefs as nothing more than manifestations of psychotic illness rather than as potentially helpful to recovery. The clinical implication for this, relate to its potential to affect diagnosis and treatment for service users.

When the participants' in this study, talked about how they started their use of traditional sources, some reported being taken to the herbalist by their family members for their symptom.

*When I started feeling unwell my mother and sister and a friend took me to the native doctor who said my sickness is a mental problem. He then gave me local medicine made of concoction to drink and bath my body with herbs (Cross River 28).*

Alternatively, others had visited a herbalist of their own accord.

*Yes at that time that I was experiencing this things it become too much for me that I had to go to see the mallam for his help. It is not easy but this man is near where I used to stay. That is he lives on the next street from my house and he works in this kind of place where you take local medicine (Katsina 27).*

Odinka et al.'s (2015) study examined help-seeking among outpatients with schizophrenia in south-east Nigeria. Here the relatives initiated contact for the first treatment option for the majority of participants, and in only a small number of cases was contact initiated by the participants. Irrespective of referral source, as Adewuya and Makanjuola (2008) reveal there is a relationship between the utilisation of native healers and beliefs about illness. Therefore, the predominant reason found for the choice of traditional healing rather than western medicine was the belief that mental health difficulties was supernatural in origin.

*You see in Nigeria, the treatment of the mental illness is taken to the herbalist because he knows where my sickness comes from and he is the only person who can heal me. But in abroad you say it is different and I do not believe that there is a herbalist in London. So in United Kingdom, I think it is strictly medical. But, here in Nigeria, everything is attributed to one thing or the other, such as witchcrafts, spirits, but I know that abroad they do not have such belief (Ogun 55).*

Ebonyi also felt that herbalists are better in dealing with this spiritual phenomenon:

*Initially when the sickness started there were some people that advised my family to take me to a native witch doctor, who can cure me in traditional way by giving me herbs to drink and bath with. These people also told my family that mental illness is the work of evil spirits and because of this that I must go to the native witch doctor who will tell me what I have done wrong and can help to talk to the evil spirit to forgive me of my sins (Ebonyi 40).*



And the idea of herbalists being better in spiritual healing also resonates in Gombe's comment:

*In that native home, they did some superstition on my chest, so that they would now reverse the spiritual forces from the body of the person and he can get better. It is like you know that this is spiritual so when you go the spiritual place for help, then you will be fine. That is all that I can say if you have a spiritual illness and then they help you to deal with the illness then it is good (Gombe 23).*

The main thrust of this, as also reflected by Adefolaju (2011), is that most people believe and rely upon the services of the practitioners for spiritual comfort. In particular, Banjo et al. (2003) found that among the Ijebu Remo, south west Nigeria, herbal mixtures were used for spiritual protection. Thus, herbal mixtures are thought to be desirable and necessary for treating a range of health problems that Western medicine does not treat adequately.

However, despite its importance, there are certain challenges. Traditional sources of care have been criticised for being unhelpful and therefore unacceptable. This view is reflected in the comments of Katsina:

*Unfortunately I do the "giya" and went back to him and telling him that I am still feeling what I am feeling. Somebody now took me to another one. I collected medicine from him, start doing it. Later I went to somebody again, he did the same thing. That is the third person. Then one of my friends invited me to come to this hospital. Before I was rejecting to come to this hospital but later I discovered it was far, far better than what I have been doing. I even promised my wife and relatives that I would not collect any traditional medicine, than this hospital because I discover it didn't work (Katsina 27).*

Similarly, after several visits to herbalists, others reported that there is no improvement in their condition as Delta notes:

*The first one gives me some kind of leaves to drink, but then I went back to him and telling him that I am still feeling what I am used to be feeling. Then I went to another one who gave me some leaves and like animals in a plate for me. After a while I now explain to him the things are still disturbing me. So I went to this third man who also like gave me leaves and animals, like the others gave me. But I can say that there were no improvements in my conditions, so I would suggest that people need hospital (Delta 37).*

Others have pointed to the problem related to numerous types of herbs. For example, Weintritt (2007) identified at least five hundred and twenty-two medicinal species used in the management of numerous ailments in Nigeria. This can result in the wrong choice for herbal treatment as is demonstrated in the opinion of Gombe:

*I think that all of these herbalists everywhere have too many things that they work with to treat us. The one I went to one I see so many things that the man has. The man was like using some things like roots. He has also many different types of leaves. I saw many things like seeds too. But sometimes he was also using animals. Like he has tortoises, lizards and insects are everywhere in this place that he is staying to work with me. It is many of the plants and different animal parts that I see him with and I think this is too many because he can begin to make mistakes, because of wrong choice (Gombe 23).*

The data further suggests that the diversity of traditional healers is a related concern, with its popularity appearing to be based on the anecdotal experiences of individuals. A further problem relates to the way in which herbal practitioners inflate the claims attached to their products, which have no scientific basis to their effectiveness, thus making it difficult to ascertain any real medicinal value:

*There are so many of these herbs, and maybe somebody will just look for leaves, trees and just combine them to start giving people without having the full scientific knowledge. Some people have the knowledge from their fore fathers but other people may be because they are redundant and have experience with the people they live around, they now advise them, do this or if you do this and that. They will now look for a shop, they will now relax there and giving peoples this and that if you take that one, may be it will have side effect (Katsina 27).*

These concerns about traditional practices point toward western medicine as a preferred remedy and many of the men sought western medicine when traditional medicine failed. As Nasarawa explains:

*I drank concoction for three months but my sickness was the same. Other family members talk to my mother to take me from there. Then one day my mother put me in lorry again to hospital. It was mum that brought me to the hospital, that time. I didn't know what I am doing. She is the one that brought me to the hospital. The doctor asked my mum some questions but I notice was not happy that my mum did not send me to the hospital when the sickness started I heard the doctor tell my mum my sickness is worse (Nasarawa 27).*

Akwa Ibom notes this too:

*Yes, I used the traditional medicine for about one month and found that it was not helpful. It is that time that when I use the traditional medicine but that the problem that is with me is not going and still there. They give me the medicine. I used it. I used it. Then I drink. And there is the one that I bath with it. But that entire one does not do anything. That is why I said that I will come to the hospital (Akwa Ibom 30).*

However, despite these concerns, some of these men mentioned that they continued to obtain help from traditional healers even after psychiatric care in western bio-medical facilities. The men who maintained contact with herbalists after western bio-medical care attributed this to a

belief in spirits as the cause of illness or the desire to be protected from a future spiritual relapse.

One can therefore deduce from these findings in this study that the traditional sources of care is complementary with western medicine. As Edo says:

*Yes, I see a native doctor. Even now I am seeing a native doctor. Actually I was given something to drink. It is herb that I was given to drink. The local medicine has its own help, because when I take it can help my brain get expand. It is herb, but I think it helps. It helps different. It has its own help, like I say because I even see its help actually and because it also helps me for sleeping. When I take it, I sleep and I see my brain widening and I will be sharp (Edo 45).*

This view is reinforced by Niger:

*Traditional medicine has a very good use in the spiritual place. To me, I think it helps to control those forces that you cannot see. Like some of those spirits will go way because of these traditional medicines. But it is not like so in the hospital. So the traditional medicines control a different thing. So I am going to see my native doctor to help me with this. But I am still taking all the medicine from the hospital too. So I am getting recovery much more from the traditional medicine and hospital (Niger 38).*

The findings of this study suggest that the use of traditional sources by the men, is not limited to herbal treatment, which emphasises the medicinal values of local plants including leaves, but some of the men also talked about the sacrifice of animals such as fowl or goats.

*When you go to the native doctor, sometimes they make sacrifices. This kind of sacrifice is sometimes different from the herbs that the native doctor give you to take. That is why I say that there can be different ways for the traditional doctors to use. The leaves that they give you to take is not bad, but sometimes they can decide that sacrifice is the best way to help you in the mental illness that you have (Kano 39).*

*The herbalist that I met said that a sacrifice that can help me with the evil spirits. He said that the sacrifice that he will make can affect me in another way. Therefore, it is important for me to do this sacrifice that he told me to do (Nassarawa 27)*

As with herbal treatment, the idea behind a sacrifice is spiritual healing. In this context the significance of visits to the herbalist is located in the belief that the evil spirits which were responsible for the affliction of mental illness can be appeased through sacrifice.

As Delta's comments reflects:

*So I go to the native witch doctor to tell me the cause of my sickness and bring like fowl to sacrifice to beg the evil spirits or idols to forgive me of my offence and take my sickness away. And they said that they have forgiven everything. In truth they said that they have forgiven everything. More than ten years I did not see any sickness. More than ten years I was sleeping fine (Delta 37).*

Osun also talks about being asked by the herbalist to sacrifice a goat as a sign of respect to spirits, as failure to make the sacrifice of the goat could incur their wrath:

*The native doctor said that he needs to sacrifice a goat. We have to go get a goat to the native doctor. When your doctor ask you to do this type of sacrifice it is to help you from any problem that you can have. It is to show respect to those spirits that are guiding you. When you show them respect they protect you from evil things (Osun 40).*

This is could be what Elebuibon (2000) means when he says that there is a fear that failure to complete a prescribed sacrifice can result in a mental illness affliction by spirits. As Adekson (2003) also suggests, sacrifice involves the appeasement of offended spirits in which the sacrifice of goats and chickens are offered in order to continue receiving blessings and to remove or keep away destructive forces. It is in this context, that animal sacrifices are regarded as gifts to the “gods” to keep clients in harmony with the “gods” and to give thanks and praises to the “gods” to help keep clients’ safe from the punishment of the spirits with mental illness affliction.

When these participants’ talked about sacrifice, their comments showed its importance was not only limited to the prevention of mental health problems, but also suggests that making a sacrifice contributes to their recovery from the condition.

*This sacrifice helps in my recovery. It helps with the symptoms that I was experiencing. When this mental illness started I was experiencing some symptoms, which was affecting me. But when I went to the herbalist he told me that there are some kind of sacrifice that he will make to help me with the symptoms that I was experiencing. As soon as he made this sacrifice I started to feel better with the symptoms that came on me (Bayelsa 34)*

Ekiti also noted that making a sacrifice helped with the relief of his symptoms:

*The symptoms that was disturbing me when this illness started reduced when I made the sacrifice. That is why I believe that the sacrifice is important in contributing to the relief of my symptoms. It is because of this, that I keep making the sacrifice to continue to remove the symptoms that I was experiencing (Ebonyi 40).*

In sum, the data suggest that when participants talked about the use of traditional sources it reflects the definition of traditional medicine by the World Health Organisation (2013c) where the traditional healer was described as a person recognised by the community in which he lives as competent to provide health care by using medicinal plants and animals. Their medical knowledge could also be used in the prevention of mental illness as well as in the improvement of the treatment of symptoms associated with the condition.

However, despite the controversy that can be associated to the benefits of traditional sources, the comments of these participants suggest the culturally bound nature of traditional medicine interlocking with western medicine. This is mirrored in Jigawa's views:

*What I mean is that some people they give you small leaves and put in a plate for you to drink with. But if you do not feel fine then you take it another time or days or say many months. It is not to say you take it one time and it will disappear, but in my own case I can say that I take it again. When the man also do the sacrifice too with the chicken it was good too. But it was like I was combining both of them. You can be doing that both like say with this you can come to hospital to help you from all that you are suffering from too (Jigawa 30).*

Similarly, Benue, held that the herbalist as well as western medicine are good:

*Both of them are good. You can use the traditional medicine say the herbalist can use his powers to take you the spirits that is disturbing you and do some of these sacrifice for you to continue to receive blessings and remove all of these evil from disturbing. As you too are now with the hospital you can continue to be coming to the hospital. Sometimes the doctor in the hospital gives you another appointment to come to the hospital as maybe he wants to check that you are okay too. So I can say traditional medicine and hospital are good (Benue 30).*

Religion and traditional sources were found to influence how the men were managing their recovery, however, as will be discussed next, family support was also cited as important.

### 7.3.3 Family influence

The findings from this study help to bring to light many of the underlying values which influence Nigerian family responses to mental illness. The lack of organised Social Welfare Services of the type seen in Western countries, means that family members often come together to reorganize and redistribute responsibilities that can no longer be carried out by the affected member. The family is therefore a very significant factor influencing the men's recovery from mental illness. Findings affirmed from a review of the literature by Mueser et al. (2013) looking at psychosocial models of recovery for people with schizophrenia where the significance of family support emerged. The role of the family was likewise highlighted in Chien et al.'s (2013) review regarding psychosocial interventions for schizophrenia within the frameworks of the recovery model of mental health. A similar finding was also noted in Tew et al.'s (2012) literature review around social factors and recovery from mental health difficulties where connectedness including family relationships was seen as vital to service users' recovery.

In many cases, data in the current study suggest that the family often took the primary responsibility for the care of relatives. For example, the majority of the men talked about being accompanied to services. This comment by Ondo reflects the views of many related to the support given when accessing services:

*I think that it was too much for me at that time. Maybe I have been sleeping when this illness started, but my brother was with me in the hospital. He was touching my hand and he said that he was the one that come to hospital with me. It was so much for me when this illness took over me. When illness take over you cannot know what is happening. It will be difficult to know what is happening to you as all of these symptoms take over you. Only the family around you can know that these symptoms are not good for you. And when they know about how it is affecting one in a bad way then they are the one that can say one is not feeling very well and needs to go to hospital (Ondo 36).*

When Osun discussed the reasons for his family accompanying him to services, he recounted the necessity of being accompanied to the prayer house when he had been found wandering in the streets.

*My family all come together and decided that what is happening to me is like mental illness. When all of the family decided to help me it was good that they accompany me to the prayer house. I was not behaving like a normal person. They see me, and at times I behave like a person is not mentally well. That is what they notice in me before they decided to accompany me to the prayer house. I thank them so much because at that time when I was there they begin to help me with all of what I was going through with those kind of spirits that was disturbing me not to sleep (Osun 40).*

As indicated, these kinds of comments show the support given by family helped the men to access a place of safety or a turning point towards recovery. However, this also shows the importance of family members playing a significant role in this regard. As Lasebikan, Owoaje and Asuzu (2012) point out, social network measures- such as less frequent contact with a family member was associated with reduced odds of accessing services.

As indicated, with the onset of mental illness these men seem to be experiencing some difficulties, but the tendency of relatives to play an important role in accompanying them to places of health care is apparent. Another aspect of this is that family members who accompanied the men often also helped as a source of information that aided health practitioners' treatment plans. As Lafia points out:

*When you go to receive these treatments, the doctor can begin to ask you some questions to know what is happening for them to decide what to do for you to get better. But since it is difficult for you to explain then may be one person in your family can talk to the doctor to help him too with what he can do to help you. In my own case, it was mum that brought me to the hospital, that time. I didn't know what I am doing. At the hospital my mum also stands in for me and acts as an important source of information and if I needed hospital admission, the hospital people can also arrange with my family. So my mum accompanying me to the hospital is helpful (Lafia 32).*

Similarly, Kwara asserts that his brother accompanying him to hospital was helpful in providing useful information that he himself could not.

*My brother is the person that provides the information for the doctor in that hospital, because I was not myself that time. When you get into this kind of sickness is it not easy for you to know what is happening. Your family that decided to help follow you can also agree to provide some information. In my own it was like affecting me but it was difficult to for to say what was happening, because it was not my normal self. Then it was my family who help to explain properly what was happening to me. It was then that was staying together, so as you are staying together at the time of this illness, it was ok for them to say what is happening to me, because they can know better (Kwara 42).*

Comments by these health professional also reflects this:

*When a patient is coming to the hospital to see us, almost all the time you find that the patient is accompanied my family members. Sometimes, it could be the wife of the patient with the patient attending at the hospital. But we do have patient's brothers, sisters accompanying them do. The other day, there were about five family members who are relatives of the patient accompanying him to the hospital. For us we are happy for the patient's relatives to accompany them because they also act as source of relevant information in aid of how diagnosis and treatment of the patient (Health professional, Abuja, 40-45)*

*In my opinion since there is no proper social services, in this country the family has to help. The family is the major provider of support to their relatives. It is not like the western societies where the social welfare services always help service users with psychiatric difficulties. Like I said these patients often rely on their families for the support they need and this is more often due to the absence of developed social services here (Health professional, Plateau 35-39).*

This sort of positive talk in which participants commented about how family relationships played a significant role in supporting their recovery, were also reported in the study by Topor et al. (2006) and strongly suggests the importance of seeing family support as a connecting link to care.



However, there were also some differences of opinions about whether families are particularly helpful. One problem noted was that service users and family carers may differ about the meaning of the act intended to be supportive. For example, the family carer may agree in general about what constitutes mental illness but disagree as to the specific choice of service. As Ebonyi states:

*When my mother was taking me to the traditional healers I was crying and fighting that I will not go but they held my hand and carried me and put me in the lorry and there they chained me and I could not run away (Ebonyi 40).*

Another man in this study reports:

*They were a problem to me, because like I said to you, when they tried out I did not like going out to that place, they now went by themselves and collect the native medicine by themselves. If I am going to eat food, they now put it inside. When they begin to put these things that they collect from the traditional man, I did not know. Because they wanted to take me to him but I said no, then they started to put all of this kind of leaves that they collected from him without telling, because they know I will not agree with this type of people (Lagos 22).*

In this context, Enugu commented on his reason for not wanting to go to the herbalist:

*I prefer to go to hospital for my illness and to see proper psychiatric doctor. It is not like the traditional man knows how to treat this illness more than the doctor in the hospital. When you have this kind of illness it is good to see the proper psychiatric doctor and not to say that you must go a traditional doctor. Because the traditional people do not know all about mental illness and for them to say that they can know more than the hospital is difficult to understand. But sometimes as you are taken to these places by your family it can be difficult for you to say you do not want to go, as they are trying to help you. But sometimes this type of help is not what you condition want (Enugu 42).*

This sort of discrepancy, as well as those reported by Ohaeri (1998), suggest the importance of considering alternative approaches to the concept of family support. As results indicate, family support does not always mean that its constituent relationships are to be viewed as only supportive for the men in this study, as the family are also likely to be sources of anxiety or concern.

Furthermore, in talking about family support, the data show that family visits are a source of companionship, which offer numerous opportunities and benefits. Turning to the significance of family visits, for Benue, visits by his wife whilst he was on hospital admission provided an important opportunity to chat with a close confidante and share ideas.

*When you are in there it is kind of not easy. It is nice that my wife was allowed to visit me. When the wife comes it is good. This is because you have someone close to you to talk to. It is good to talk and when you talk the wife can share ideas with you and provide advice to each other. I love talking to people, so I become very happy when my wife visits me. In this place the visits are regular and sometimes my wife will be allowed to stay from morning till evening or even stay overnight. During this period we can talk together as one family and share our ideas together (Benue 30).*

This is also exemplified in a study by Ohaeri (1998) which explored the perception of a social support role of the extended family network by some Nigerians with schizophrenia. It showed that the closest social interaction was offered by family members. At the same time, others saw social interaction through family visits as an opportunity for providing dietary necessities, as it was common for visiting relatives to bring along food. Thus family interaction, is beneficial as it offers opportunities for confidences and support expected from the relative visiting, as this comment by Delta demonstrates:

*My family people are great source of support to me. For example, the other time when my cousin she was coming she brought food for me. Anytime that she is coming she always brings something for me and this makes me happy. I enjoy the food so much because that is what I used to eat when I was at home. It nice of my relatives comes with some kind of help. When my aunt was coming she brought food. She brought me pounded yam and egusi soup and it was really nice in the mouth, so it made me to feel better with myself (Delta 37).*

As indicated earlier, non-adherence to medication has been associated with the risk of exacerbation of symptoms, psychotic relapse and re-hospitalization (Ascher-Svanum, et al., 2006). However, when asked about their perceptions and experiences of medication, family support was highlighted as influencing compliance.

In particular, some participants highlighted the important role family members played in prompting them to take medicines.

*My wife helps me to remind me to take my drugs. My family, my parents always reminds me and always advises me. There was a time that, I stopped taking medication, but they encouraged me to not to stop taking my medication as it can bring back my symptoms. The advice from the family has being very good and have encouraged me not to stay off my medication (Kano 39).*

As Garcia et al. (2006) found in a sample of thirty Mexican American individuals with schizophrenia, higher levels of family support were associated with greater likelihood of medication usage. Among Nigerian out-patients Adelufosi et al. (2012) also reported that individuals with families who supervise their use of medication have been found to be more medication adherent than those who are unsupervised or living alone. Thus for, Gombe for example, the reason for seeking family support in this way is that sometimes one needs prompting as otherwise one is likely to forget:

*Sometimes you can forget to take this medication and this is why I say that the family that come to help you is important. Because they can talk to you that you need to take the medication at a particular time. And at this particular time they can help you with bringing the medicines out of the cupboard that it is kept. It is not always that you can remember to take these medicines, but with you family to help to remind you then it is okay. You can get on to continue to take the medicines with the help of your family. That is the reason I say the family help me to get well with the taking of my medicines (Gombe 23).*

However, the influence of family aiding medication usage was not viewed as helpful in all cases. Negative talk included highly emotional examples of verbal exchanges of a negative, oppositional or hostile nature (Kymalainen and Weisman, 2008). As this comment from Nasarawa demonstrates:

*It is humiliating with them telling me to take my medication every time. It is the way that they keep saying about it that makes me angry. Sometimes he brings the medicines to me and begin to shout at me to take them. Even when I have taken it, say the one for morning time and she was not at home, but immediately say comes back, he start shouting asking me if I have taken my medicine. But when I say that I have, say begins to shout saying that maybe I don't want to take my medicine and shouting that I have to take another medicine in his presence. This really makes me to be angry (Nasarawa 27).*

Similar arguments that strongly expressed emotional tension in families is a major psychosocial stressor was documented by both Nirmala, Vranda and Reddy's (2011) and Moller-Leimkuhler and Wiesheu's (2012) research. One way in which this conflict acted negatively was in the withdrawal from the family support network.

Lagos said this of his family:

*Because then people think that I am mad, when my family used to run away from me, if I talk to them, they used to mock me. They started mocking me, saying that I am mad. Even now if I went to our village, they started introducing me as mad person and that thing is paining me and because of this I will withdraw from talking to my family (Lagos 22).*

Consequently, one implication of this is not only withdrawal from the family network but as Breitborde et al. (2009) suggest this type of hostility means less family support, often with an associated deterioration in the health of the individual.

Jigawa explains:

*It was too much for me to bear, so I had to leave home because I did not know what to do. As I was under support by my family but if some of them just begin to talk and this is not making me feel good but making me feel bad. As a man these kinds of disturbances that you are getting can make you feel really bad. It can make you feel really bad especially if you don't know what to do. In my own case it made me one day to begin to roam around the streets (Jigawa 30).*

As previously indicated, psychiatric hospitals payments are required before treatments are administered and this payment-before-treatment further illustrates the kinds of burden the men and their family were experiencing. This is exemplified in the following comment by Lafia:

*It is said that we need to pay all of this money before we can start treatment. So my family members pay for my hospital bills. And that is a problem because this payment is made in cash to the hospital cashier often for my hospital admission. It was when we came to the hospital but the doctor now said to us to go and pay money. We have to go and pay money to counter, then come and show him the receipt, before he can now begin to treat my case. This is what we have to do to get treatment. That is we need to pay this money to the hospital (Lafia 32).*

This issue also came up in discussions with health professionals in this study:

*It is the hospital policy that we checked with patients that correct money has been paid to hospital cashiers and receipt presented before treatment. It is a dilemma for us but we have to adhere to hospital policy that require that patients make payments for the services that are to be administered (Health professional, Dutse 30-35)*

*Checking that patients has made payments before my attending to the patient is one part of the job that is quite demanding. Often the patient is accompanied by family members and you have to start inquiring if the appropriate payment has been made. The family members are aware of this, but sometimes it is difficult for them to be honest and it is at this times that there is a moral dilemma for me. For example, I know that in western countries such patients are allowed treatments to aid their recovery, unfortunately for them her in Nigeria, there is a need to make payments before commencement of treatments (Health professional, Yobe 40-45)*

However, as Imo pointed out, it seems that during illness emergencies some of these men might not have the required cash to pay for these hospital services.

*Sometimes when this sickness start we don't always know when it is going to start or when it is going to come again. And like when you don't have money what are you going to do. It is very difficult for us. Because if we don't have the money then we will not be able to receive the treatment, as they will just tell you to bring money. When they tell you to bring money and you don't have then it would not be possible to get treatment. It is always problems, as sometimes when you don't know when this illness is going to start and maybe you do not have any money to pay at that time as it just come upon you (Imo 28).*

This issue was also discussed by Eaton et al. (2015) among patients in Cote d'Ivoire, West Africa where hospital admissions are prohibitively expensive for many. The daily hospital admission cost is about sixteen United States dollars per day, while the average daily individual income is only about three dollars. A similar argument was reflected in a Nigerian study where Abiama and Ifeagwazi (2015) suggest that the family was the financial provider and expected to make payments for hospital treatments of their relatives.

The financial support for the men in this study was often provided by the family, including spouses, parents, and children of a service user. However, as the findings suggests some of the men were worried about the consequence of their inability to make cash payments for western bio-medical care. The danger with this as Kaduna explains, is that individuals may be deprived of the mental health care that they need, with resultant recourse to cheaper alternative sources, which may not be the preferred treatment option.

*When we got there we could not get treatment. If there is no money to pay then you have to go another place for them to help you. Sometime even if you feel you need to come to hospital but because you don't have the money to pay then the people that you are with can take you to a different place. Maybe you can end up where you don't want to go. So it is a dangerous situation, not to have the money to pay. Because when you don't have this kind of money to pay of course you have to do something to get better from what you are feeling, so you can end up with the wrong place because of lack of money (Kaduna 30).*

This combination of findings provides some support for the premise that informal family caregivers are experiencing huge burdens. Notably families are expected to care for relatives including making payments for hospital psychiatric services out of their own pocket. As Ohaeri (2001) opined, another feature of this is that the family burden of caring for relatives with schizophrenia is probably worsened by more financial responsibilities especially in the absence of social welfare services.

Apart from payments for medical treatments, family financial assistance helps with hospital attendance. For example, Akwa Ibom, claims that family financial assistance with transport costs enabled him to attend hospital appointments or consultation with a psychiatrist.

*It was my mother that used to help with transport money for me to hospital. All of the transport she used to pay. If she does not pay it will be difficult for me the hospital. Because when you come first time, the doctor give you card and say at this day and time you have to come to see him. It is important to come so that he can check you up to see how you are getting better. So if my mother does not give transport money, it will be difficult to see the hospital people (Awka Ibom 30).*

This is representative of what Adelufosi et al. (2012) mean when they indicated that the high clinic attendance found among many out-patients in their study who live far away is accounted for by the fact that transportation costs to the hospital, was borne by family members. However, as Adewuya and Makanjuola (2010) found, transport costs might consume well over half of a family's monthly income. As a result, although many may understand the importance of outpatient clinical reviews, nonetheless, inability to attend hospital appointments due to lack

of transport money, can greatly add to feelings of helplessness. This same kind of insecurity came into play in another men's comments:

*What will I do when there is no transport money for me to come to the hospital for the appointment which the doctor wrote for me to come to find out about my illness? It is not as if I did not try to get the transport money, but everybody that I asked could not find the money. And that is the problem, because it will be difficult to get money from anywhere, if your family does not come to help. And if your family is struggling to help, the problem is even more for you. Maybe if I miss this appointment again my conditions can get bad. But it is the lack of transport money that I am facing that makes me to miss the appointment. When you lack this transport money it is not easy to come to hospital (Abia 29).*

And as one health professional concurs:

*Transportation money is a big concern for a lot of the patients that I see in my clinic. To be fair to them, they seemed to want to come to us, but some of them do not have enough money to pay for their transport to come to the hospital. Some of them might not have a means of income and may have to rely on their family for transport money, and sometimes they do get disappointed when the family is unable to assist with their travelling to hospital (Health professional, Yola 25-29).*

It is in recognition of this difficulty that Oyo, another health practitioner suggests:

*I think the government should help financially as we have in developed countries when patients with mental illness can be helped. Not only should the government help the patients the government should help the families too. You see a man without money in Nigeria is a dying man and if he has mental illness and also does not have money it will be difficult for him to recover (Health professional, Oyo 35-39)*

As noted then, western medicine, traditional medicine and family support are all of significance in the participants' views about recovery. However, as will be further discussed, another key feature emerging from this study is the importance of gender flexibility in relation to men's recovery.

### 7.3.4 Influence of gender flexibility

The data from this current study highlight the changing nature of masculinity within the Nigerian context. Some of the participants were embracing flexibility in gender relations, in contrast to traditional gender practices, and this was found to be an important influence on recovery.

Here is part of the conversation with one of the men who participated in the study:

*Interviewer: What if you are unwell and need help?*

*Participant: When the man is not feeling well, and wants to go this doctor, he can. The man will be happy to go and get help as he knows that his wife will also be happy to provide for the children (Katina, 27).*

Nicoleau et al's. (2014) study among twenty-one couples in the United States of America, showed how spouses are influenced by changes in each other's situations. In the United Kingdom, Hauari and Hollingworth's study (2009) found an unwell father's ability to provide for their families was severely limited, with changes in gender relations due to the male provider being unwell also reported. As Ebonyi comments:

*All of my family come to together. It was one weekend that everybody come to the house and everybody sit down together to talk about what is going on in the house. Before when I was not sick, they know that I was doing my best for them. So I am happy that my family came together to talk about how the family will do, because of this sickness that is disturbing (Ebonyi, 40).*

As previously discussed traditional views of gender describe a model of household relations which embodies ideas about the role of the male provider.

*I had to keep providing for the family. Sometimes your health is not too good, but you still keep doing what you have to do to make sure there is no problem in the house. That is what a man is expected to do, he has to be going out to make good things happen for family (Oguni, 55)*

This pressure is further reflected in the following comments:

*The symptoms that I was having was not much. When I see that the symptoms is not too much, I will not lay down on the bed. If I lay down too much on the bed, I know that it will be difficult for me to live and even it will be difficult for my family as well. A man should not lay down on the bed when he knows that he has to get up to do some work to bring money for his family. A man is not a lazy man and expected to work (Bauchi, 27)*



However, in contrast, to these traditional masculine expectations, the emerging gender flexibility reflects changes in the practices of family members of the household. As the data indicate, this changing nature of gender relations within the Nigerian context, is linked to improved opportunities for female participation in business.

*We are happy in the family. When someone cannot do something and the other person can do them everybody will feel happy. I was very happy when my wife started to do small business to bring little money. It was a small business that she started because everybody see that it is very difficult for me. When it difficult for person and the other can start business then it is very good. It is a small business, but she started going to the market to sell foodstuffs and with the money she was making we are trying to help everyone in the family (Benue, 30).*

*I was the person doing everything as a man, but now there is a business centre near the place that we live and my wife started to go there to help to type documents for the people. You know she is able to type very well (Anambra 37).*

As Nwoye (2013) suggest a significant reason behind females starting a business include meeting family needs. The implication of this shared responsibility, as indicated, was a reduction in some of the pressures that were seen as significant in causing episodes of schizophrenia and the ability of the men to become involved in their recovery.

## 7.4 Summary

In this chapter, I discussed the theme of recovery. In particular, the participants' definitions of recovery highlight it as getting better, involving relief of symptoms associated with mental health difficulties and a return to expected social roles. When the study participants talked about the factors influencing recovery from their condition, it highlights recovery as multifactorial involving western medicine, traditional medicine and family support. However, a notion, which emerged from this study, is the importance of shifting ideas of masculinity and the emergence of gender flexibility in the participants' views about their recovery.

## CHAPTER EIGHT: DISCUSSION OF FINDINGS

### 8.1 Introduction

This discussion chapter addresses the research questions in considering the participants' perceptions and experiences of developing schizophrenia and what factors were found to be important in influencing recovery from the mental health problem. It explores data from the three key findings chapters focussing initially on the men's changing beliefs regarding the cause of schizophrenia then exploring gender flexibility in a changing Nigerian masculinity and its role in the men's recovery. Finally, it considers how these Nigerian participants' views concur, contradict and help illuminate what factors aided recovery linking this to current literature about approaches to recovery.

### 8.2 Changing beliefs: western medicine, religion and causation of schizophrenia

Drawing on the data from previous literature, lay conceptualisations of schizophrenia were often highlighted as having a multifactorial aetiology. This view of the condition, was certainly reflected in the data in this study. Being head of the household is one of the ways men in this current study talked about social expectations related to traditional views about gender. There was evidence that, for many of the men, being married becoming a husband and fathering children, facilitates a new, significant and important status as head of the household; an important signifier of a new life stage representing maturity. Similar constructions of these traditional views about gender also emerged in prior literature including in Morrell and Ouzgane's (2005) African study where they suggest that the concept of being a head of the household is a fundamental outcome of marriage and at the same time an important measure and aspect of being an African man. Whilst highly desired, being head of the household through marriage is also a dominant source of worry for these men because of the related costs in

formalising marriage, such as the bride-price and the ceremony. A Nigerian study, by Onyima (2015) reinforces this view in suggesting that the fulfilment of traditional expectations associated with marriage are sources of immense pressure for men in these communities.

Collectively then, these particular male role expectations were seen by the men in the current study as potential factors in the development of their mental health concern. In addition, the men in this study narrated how this pressure is made worse because of the ridicule experienced by those not meeting these expectations. The shame and pressure on the men who are unmarried seems widespread, and, in line with Uchendu's (2007) study, suggests that among many communities in Nigeria, an unmarried male is frequently perceived as an irresponsible man. Uchendu's (2007) explorations of gender among Nigerian university students, showed that an unmarried male was barred from vying for elective positions and excluded from holding political appointments.

As the men's experiences highlight, traditional gender views are often constructed in the context of the expectations made about the nature of man as head of the household. Although, marriage is important, it is not an end in itself but rather the beginning of a long journey on the road to fulfilling other masculine expectations. The primacy of work is also an important gendered belief, and cited as being significant for fulfilling other expectations of being a man such as being the breadwinner and the head of household. In addition to the provision of accommodation, when many of the men talked about the concept of being the head of household, they constructed views of the husband and father as a provider. Because a man's position in the family is that of head of house, he has the responsibility of finding the money for housing, clothes and food to feed the family. Thus, a man in these Nigerian communities is

called the breadwinner because there is a moral (gendered) obligation that he ought to provide financially and materially not only for his wife and children but also every person living in his household. The findings of the current study reveal that the expectations for these men to provide in this way has also been extended to include the material and financial needs of the wider family; paying for their children's education in terms of school fees and school requirements. In addition, the study reveals that a man is expected to take care of his family by providing for health care which clearly creates an issue when he himself is the one identified as being unwell. These issues have come up in other studies such as those by Barker and Ricardo (2005) and Ratele (2008) where the expectations on men as head of the family generates a range of masculine burdens that (morally) need to be fulfilled.

The findings of this current study highlight how men in this community in northern Nigeria, were struggling to live up to these gendered expectations. The danger here is that some men could be going to extreme lengths to obtain the money to meet these gendered expectations. Some talked about how they were working long hours without rest and having to wake up very early in the morning to catch the bus to work. In this sense the data from this study, reflects the finding within Somoye, Babalola and Adebawale's (2015) Nigerian study where they highlight how men's higher susceptibility to health problems are associated with gender practices requiring them to endure long working hours.

This view is not limited to Nigeria and the wider Africa context, as late in the 1970's, the complex interaction between biological and societal experiences, including their causal roles, began to be recognised in the global North following the work of an American psychiatrist, George Engel. His work highlighted a new approach for viewing illness onset referred to as

bio-psychosocial model (Engel, 1977) which also involves a vulnerability-stress hypothesis where the effect of stressors such as adverse life events were similarly highlighted as a trigger for mental illness (Zubin and Spring, 1977).

In light of this, the findings of this current study also relate to Pleck's (1995) gender role strain paradigm, in the sense that men could experience dysfunction strain and pressure where struggling to live up to gendered expectations heightens their susceptibility to illness. In this part of northern Nigeria, for instance, traditional gender practices, particularly the establishment of a household by being married and fathering children, facilitate a positive gender identity. However, as the men's experiences show, this also puts pressure on them as the household head to provide and oversee their family's well-being. Along with this, the shame and ridicule when they could not meet these gender expectations not only elucidates Pleck's (1995) role strain but was cited by these participants in this current study, as a trigger exacerbating their acute schizophrenic episode. In the United Kingdom, Goh and Agius (2010) also suggest that although individuals inherit a genetic disposition to mental health difficulties, this vulnerability in itself is not sufficient to manifest symptoms associated with the condition as this requires interaction with psychosocial stressors. It was also in this context, which Freeman et al. (2013) suggests that the majority of their participants endorsed stress from interpersonal problems as the main cause of their mental health experiences.

The participants' causal beliefs about schizophrenia in this community in northern Nigeria suggests that psychosocial factors are of key importance. The pressure for men to function well as the head of the household and to oversee his family needs was highlighted as a trigger

exacerbating acute schizophrenic episodes. However, as will be discussed further, there are alternative, or additional, causative explanations to the conceptualisation of schizophrenia.

It is in light of this that the results discussed in following section in relation to alternative or additional frameworks to explain onset of schizophrenia, offer insights into how the religious-spiritual beliefs of some of these Nigerian participants' influenced a construction of a superhuman image of God as being fully or partly responsible for mental health difficulties. In a Nigerian study which explored lay beliefs regarding the cause of mental health difficulties in south-western community, Adewuya and Makanjuola (2008) similarly found a widespread religious belief about the onset of the condition which was attributable to God's will. Perhaps this is about a difference in health beliefs in Africa and that in western societies. However, Adepoju's (2012) study which examines health beliefs in the United States of America, found that the belief of an invincible God, referred to as Olodumare, is common among African Americans. In the United Kingdom, this religious-spiritual belief was also found to be a strong influence among the Muslim participants in Khalifa et al's. (2011) study in their explanations of how their mental health problems arose in that study.

Within the current study, alongside the construction of mental health problem as a religious God's will phenomenon, others cited spirit possession. Collectively drawing on the data from this study, this sort of religious-spiritual beliefs is often perceived as a connectedness to a Supreme Being. Often among these participants' spiritual explanations reflected a type of relationship or even communication with spirits that are believed to play an important role in influencing the wellbeing of their living descendants, including inflicting mental health problems. This view is supported by Aghukwa (2012) Nigerian study where patients and their

families expressed the belief of ancestral spirits as the cause of mental health difficulties. In South Africa, Bojuwoye (2013) also discusses causal beliefs associated with ancestral spirits. This framework suggests that these religious-spiritual beliefs do not exist in isolation but merge and impact on mental health difficulties construction as well as reflecting the complex nature of the participants' constructs of schizophrenia in this study. As Kanu (2014) suggests in his work which explored African traditional religion, the majority of these communities explained their mental health difficulties in a religious nature or even through a more general spiritual lens and this has indeed been the case in the current study.

The present findings lend support to the important influence of religious-spiritual beliefs in contributing to the participants' constructions of the mental health problems. However, there is more involved than just this, in particular the experience of stigma and increases in social distance towards people with mental illness. As demonstrated, underlying the religious-spiritual beliefs about the cause of their mental health problem were explanations that the condition was brought on by God and/or spirits due to one's sinful ways. The association of mental illness with engaging in behaviour believed to be forbidden, could be regarded as positive where it represents a system of prohibitions due to its restraining effect on certain behaviours. Afe (2013) has argued that among traditional Nigeria societies, the early religious-spiritual association of mental health difficulties with punishment by God and spirits possession was attributable to the condemnation of incest. This perception of being afflicted with the condition by God and/or spirits, was also reported by Omobola (2013) among the Yoruba of southwest of Nigeria as something that could have restraining effects on some people's use of illicit drugs.

However, another feature of this religious-spiritual causal belief is in the idea that the mental health problem could also be viewed as a moral lapse, or as 'self-inflicted', and therefore increasing social distance by family and friends towards them. This kind of view was also strongly expressed in a study by Audu et al. (2011) among 325 inhabitants of a rural community in northern Nigeria. Many participants believed mental health difficulties as a punishment from God for sins and evils committed by the sufferer such as their use of Indian hemp. While this view may help discourage the use of illicit drugs, it also carries the disadvantage of influencing the community to see mental illness as a self-inflicted behavioural consequence of illicit substance use with all the associated moral implications. Not surprisingly then, these negative views were also reported to affect these communities level of social relationship with those with mental health problems. In particular, their study found that these views worsen the attitude towards those with the condition with only a few participants reporting being willing to have a friend with a history of mental health difficulties. Similar views were also strongly expressed in a study by Crabb et al (2012) among 210 participants attending clinics in a psychiatric hospital in Malawi where there was a suggestion that their experience of stigma was characterised by blame for their mental illness attributed to alcohol/illicit drug use.

Given this, the notion of schizophrenia being brought about by the will of God, or by possession by spirits, reflects the religious-spiritual beliefs found within this data. However, complications in western bio-medical practice for the men, can then arise from these traditional beliefs about the causes of their mental health problem. In several instances, health professionals in this study referred to the dilemma they encounter around patients with religious-spiritual beliefs as part of their everyday clinical practice. As the comments of these health practitioners' in this study demonstrates, it could be difficult to distinguish these religious beliefs from delusions. Therefore, it seems that the health professionals view the dilemma the men had regarding their



religious views about onset of their mental health problem explaining it as unscientific and have consequently underemphasised religious views as causal theme in schizophrenia within this study. As Dein (2004) suggests within western societies, mental health professionals, could be less religious than their patients, further explaining as the comments of the health professionals in this current study demonstrates that the topic of religion plays little part in medical training. Therefore, this meant as pointed out that the male service users religious views about their schizophrenia were underemphasised as explanation for their mental health condition by the health professionals in this study.

Whilst religious-spiritual beliefs played a part in the accounts of causation for schizophrenia other explanations also played a part. When these Nigerian participants' further illustrate their perceptions and experience of schizophrenia, the significance of a western framework also emerged, where biological conceptualisations of the cause of schizophrenia were highlighted. When some of these participants' talked about this, their comments suggested that there is a bad gene that can confer a risk of schizophrenia. This link of a relationship between genetics and risk of schizophrenia was strongly supported by Harper, Towers-Evans and MacCabe's (2015) study in Sweden where both parents receiving a diagnosis of schizophrenia led to the greatest increase in risk in offspring. Their findings also suggest that one parent receiving a diagnosis substantially increased risk. An association was also reported for relatives (uncles/aunts) with a diagnosis as well as their siblings.

Perhaps the views in this study, in highlighting the relationship between genetics as a factor in onset of schizophrenia was about their desire to concur to western biomedical models. Therefore, it seems that viewing the cause of their mental health problem as biological was

behind some of the participants' willingness to adopt western medicine. In Germany, the study by Wiesjahn et al. (2014) also found that biological causal belief helped service users to view medications as important. This has been similarly noted in Furnham and Igboaka's (2007) cross-national study where biological conceptualisations of mental illness as a disease were shown to influence participants' adherence to a model of western biomedical treatment. In their study they compared the causal beliefs and treatment of schizophrenia in a similar sample of young Nigerians and British, in their respective countries. While the former were found to endorse religious-spiritual beliefs, they also cited biological explanations. Furthermore, while Nigerians in this sample recognised traditional sources and religious practices as possible treatment options, some also favoured western-type psychiatric interventions and supportive environments as treatment models. Taken overall, the British participant's favoured the biological (genetics) as possible causes and this influenced their choice of a western medical regime. This was also the explanation for choosing western medicine by the Nigerian participants in this study.

In summary, the findings in this current study suggest that participants' with schizophrenia hold multiple explanatory models. They held religious-spiritual beliefs but also cited genetic susceptibility as influencing their biological beliefs for schizophrenia. However, there is also an additional emerging shift in participants' perceptions of schizophrenia in this northern part of Nigeria related to recognising the impact of gender expectations. Specifically, as the data reveals the pressure for a man to function as the head of the household in a changing socio-economic climate, overseeing his family needs, was cited as an emerging trigger for causing or exacerbating acute schizophrenic episodes.

### 8.3 Role of gender flexibility in men's recovery

The findings of this study suggest that some traditional views around masculinity are changing amongst the men in this community of northern Nigeria. As highlighted, a dominant masculinity is still often perceived as the ideal form of manliness within traditional Nigerian societies, where individuals do gender by behaviours that are perceived as either masculine or feminine; such as by fulfilling a traditional male head of the household model. As discussed earlier, behaviours usually associated with this family headship concept include the establishment of a household by getting married, becoming a husband and a father of children. Alongside this comes having a job, earning a salary or getting money by other means to meet the needs of their family. As Barker and Ricardo (2005) suggest, often closely related to this traditional view is the emphasis on hegemonic masculinity where, in the wider African context, the male is regarded as breadwinner.

However, in contrast to traditional gendered discourse the data in this study also suggests that constructs of hegemonic masculinity were in transition. This is illustrated by the comments of the men which indicate that whilst striving to live-up to traditional expectations there are also opportunities for acceptable alternatives to these expected norms and how these norms can shift over time. The data within this study is not alone in suggesting that hegemonic masculinity in society can change. As Anderson's (2005) point out men are becoming more willing, often eager, to participate in role reversal activities otherwise considered inappropriate by men with traditional gender expectations. Bridges and Pascoe (2014) provide further understanding of this, where contemporary transformations in masculine expectations is understood as challenging traditional views of gender expectations. Within the global North similar findings of shifts in gender relations, termed gender flexibility by Nicoleau et al. (2014), likewise suggest that in contrast to traditionally fixed notions of household tasks, new flexibility in

gender relations is also present allowing some families to distance themselves from hegemonic norms and values, a blurring gender differences and previous perceived boundaries.

In particular, as the data demonstrates gender flexibility in Nigerian context reflects the changing practices of household family members. Emerging contemporary views about gender highlight some shifts from traditional ideals of the man as principally a breadwinner to one who shares responsibility for a range of activities with his partner with some households reporting changes in gender relationships that provide opportunities for greater female involvement in the material and financial needs of their family.

Alongside this, these participants' views of mental health concerns and its recovery highlights influences that contribute to more flexible notion of gender. Indeed wider social changes on women's position in Nigerian society have emerged. As the data revealed in distressing economic situations, the traditional concept of the men as the family breadwinner became challenged. The doing of gender, then where masculinity hinged on the sole ability to financially provide for the family was constrained adding to the health burden of these men. Therefore, through the need for solutions and to ensure financial survival, the women become equally important for ensuring the financial wellbeing of the family. As a result, many traditional male earner or provider households were required to explore alternative household practices. One feature of this was the emergence of changing expectation within the households and the ways in which these participants' in the study accepted or struggled to accept this shift impacted on their road to recovery.

The view among the participants about changes in household gender relations was not limited to difficult economic situations. The transformation from traditional masculinity roles was also influenced by education. When the participants' talked more about this it seems that their current thinking about female participation in education is also undergoing change in Nigeria. They recognised the importance of women becoming educated in reducing some of the psychosocial pressures that contributed to their schizophrenia and also in more gender equitable arrangements that could help recovery. This type of positive talk significantly reflects the increasing females participation in education in areas previously recognised as the exclusive preserve of the male. As Nwosu (2012) observed among Nigerian communities, this new development provides a new status for females through development of new skills and the subsequent opening up of more opportunities for them; including being a contributing factor in their getting better jobs.

Arowolo and Aluko's (2010) study explored political participation of women in Nigerian society where work within government was reported as a major source of employment and income. Indeed, globally, wider social changes on women's position in society have emerged because of governments' adoption of the United Nations Beijing Declaration frameworks for supporting women empowerment that was the outcome of the Fourth World Conference on women held in Beijing, China in September 1995 (United Nations, 1995). As Arowolo and Aluko (2010) observed in Nigeria, since the Beijing Declaration on women's empowerment, the global proportion of women in parliament has nearly doubled, growing from 11 percent in 1995 to 22 percent in January 2015 (United Nations, 2015). This view about women changing position in Nigeria was also reflected in Oluwagbemi-Jacob and Chima's (2015) study, where it was reported that women were supporting their husbands in making financial provisions for their family sustenance due to their success in commerce. This emerging flexibility in defining

the household within the literature was then associated with the emergence of changing household expectations and therefore changing roles for men.

In terms of their recovery, the men's experience in the current study suggests that gender flexibility has been linked with improving the health not only of the men but also improving conditions for those around them. The importance of gender flexibility, discussed in relation to what the men's experience has shown, often represent a turning point in their recovery journey. This concept of gender flexibility, where household members regularly crossed traditional gendered expectations and their contributions to the household changed over time, was significant for the men in creating new spaces to help the recovery process. It meant both they and others around them embracing an alternative model of gender relations, in contrast to traditional beliefs and practices. However, the advantage of this was to reduce some of the psychosocial pressures that were seen as instrumental in causing the mental health issue and also in limiting recovery from it. Therefore, this emerging flexibility in household practices represented an important factor in the men's recovery. It is significant to the men's recovery in this northern part of Nigeria because, with the emergence gender flexibility, how best to provide for family needs becomes more of a shared responsibility and this helps address the pressures that may play a role in men's mental health concerns or aid in pathways to recovery.

This position is also strongly reflected in the work of Odimegwu and Adedini (2013) with Igbo men in south-east Nigeria. Most participants in that study expressed a willingness to influence their recovery through, for example, participation in health programmes. However, the timing and opportunity to do so was influenced by other factors such as female partners' ability to meet the children's needs. As the United Nations Millennium Development Goal Report

(United Nations, 2015) suggest changes in women's position within society promotes gender equality and poverty reduction. The changing nature of masculinity, that stands in contrast to the traditional male-provider family was similarly reflected in Oyekanmi's (2015) study, where new flexibility in defining the household was significant in the weakening of boundaries around societal gender expectations, where financially providing for the family needs were expectations for a man. Therefore, as seen in this current study, for some families, flexibility in household relationships, in contrast to traditional views, is crucial in providing opportunities associated with men's health.

Following on from the masculine theories presented in this section, the current study helps provide further evidence that gendered identity, including masculinity, can and does change. While the understanding of masculinities are continually being constructed, the acknowledgement and importance of changing masculinity is emerging in contemporary Nigeria and this current work suggests that such gender flexibility can be an important influence in contributing to recovery from schizophrenia.

## 8.4 Views about recovery from schizophrenia

In this study the data highlights recovery from mental health problem as involving a process or a journey. When the participants' talked about this, the core concepts that define recovery as a journey included symptoms becoming less severe as well as being able to take on meaningful roles; that is, as well as being able to function and contribute in socially ascribed ways. Although meeting expectations was important, the findings of this study also highlights flexibility around household responsibilities as of key significance to recovery.

Understanding recovery in this way is embedded in the notion of change and progress within the illness journey. This also resonates with the idea emerging from observations of participants' with schizophrenia in Spaniol et al.'s (2002) study in the United States. In the model they developed, the process was characterised as involving a progression, through three broad phases "overwhelmed by" "struggling with" and "living with" the disability. As participants moved through these phases, they worked on three basic tasks: they sought an explanation for their experience, they tried to control the disability and they attempted to establish themselves in meaningful and productive roles.

These phases link with the current study. As the data revealed with the onset of schizophrenia came the emergence of psychotic symptoms, such as one man roaming the streets naked. Another of the men, who was employed, began wandering into areas, whilst trying to go to work, such that he could no longer locate his work site. A further participant had to discontinue his education, as he was hearing voices which affected his concentration. Experiencing psychotic symptoms was associated with an acute phase of schizophrenia, where many of the men in this current study felt stuck. This resonates with what Spaniol et al. (2002) described as



a phase of being overwhelmed, when during the onset of the mental illness many often felt confused due to the symptoms of the condition.

As the data within this study suggests, recovery was further delineated as a process of engagement with resources which not only facilitated the male service users' getting better, but also contributed in their journey towards the attainment of symptom relief and improved ability to meet gendered expectations. As will be discussed, the service users' who progressed in recovery tended to have support to help manage the challenging processes involved in this recovery. The presence of one or more supportive people in their lives seemed to be essential. Therefore, the idea of recovery involving some control over the illness itself, suggested in previous recovery literature, was also reflected in this current study. With regards to this, Whitely (2010) cites the reduction or control of symptoms so that they do not overwhelm or incapacitate the service users' as of key importance.

However, findings from the current study suggest that the lessening of symptoms is not only the essential feature for demonstrating recovery. Rather than viewing the lessening of symptoms as a (or even the) primary outcome of recovery, making progress without necessarily achieving the elimination of symptoms was cited as relevant and important. With regards to this, a significant feature of recovery was seen as a move into roles that were meaningful, productive, and valued in the larger community or society. As previously discussed, this indicator of recovery talked about includes being in employment. However, the participants were also often simultaneously trying to (re)establish themselves as head of their household. This view of recovery involving restoration of roles within the family is supported by health professionals in this study, where their comments then indicate that symptomatic remission

among patients with schizophrenia is often associated with an improved social functioning. As Liberman (2012) suggests improvements in symptomatic impairments which can intrude on activities of daily life can lead to improved social functioning among patients recovering from schizophrenia.

Taken together, the definitions of recovery in this study suggests being in recovery as a process that involves gaining or regaining many aspects of functioning in socially ascribed ways, that may have been lost or severely compromised initially by their mental illness. Contrary to the traditionally pessimistic view of the course of schizophrenia by Kraepelin (1919) that people with schizophrenia do not recover, the findings of this current study highlight the possibility of recovery or at least a progress and journey toward this. Although the meaning of recovery as the data revealed involved the reestablishment of gendered expectations, however, as was discussed there is an emerging gender flexibility in the household. This notion of recovery which contrasts with the traditional expectations of gender were said to play a role in the men's recovery. In light of this understanding, this study provide data which highlights recovery as multifactorial.

When the participants discussed recovery as multifactorial, hospitalisation was described as providing support to some of the men to protect them from the risk of self-harm or harm to others because of the acute symptoms associated with the mental health difficulties, such as endangering themselves by roaming the streets. As Muir-Cochrane and Gerace (2015) suggest, the experience of psychiatric inpatient hospitalisation has received increasing scrutiny over recent years where risks of self-harm and /or risks of harm to others is usually the main reason for admission to hospital. This position is strongly reflected in the study by Jones et al. (2010)

which explores the experiences of service users on acute inpatient psychiatric wards where acute inpatient care was seen as helpful at a time of great distress related to the management of acute symptoms of their condition. Although, some of the men linked hospital admission, to the management of their condition, there were concerns about how people wandering around the ward, the noisy environment and the disruptions to electricity supply made them feel insecure and unsafe. Additionally, this insecurity affected their sleep. In sharing the views of the men about difficulties experienced in ward environment, some of the health professionals in this study explained that limited financial resources to hospital management to support their comprehensive implementation of safety measures is a significant concern in the running of the hospital facility. Perhaps this is about a difference in the standard of care in western biomedical care in Nigeria and that in the Global North. However, Stenhouse's (2013) study which explored patients' experience of safety in acute psychiatric care among 13 inpatients psychiatric ward in the United Kingdom provides evidence in support of this sort of negative view. The findings of that study suggests that participants initially experienced a sense of safety within the ward environment, however, a key issue to their feeling unsafe was their perception of the threat from wandering patients. It is more likely then that early initial feelings of safety for self and others (whilst in an acute state) are replaced by feelings of concern and even fear once symptoms are controlled and the environment viewed differently. This resonates with the negative view of hospitalisation as reflected within the anti-psychiatry critique such as those by Goffman (1961) and Cooper (1967) and also raises concerns about the role of institutional care on the health of individuals.

Furthermore, in this study, the improvements in the symptoms associated with mental health difficulties were reflected through their contact with a psychiatrist which facilitates western medicine involving anti-psychotic medication. In the United Kingdom, this position is reflected

in the National Institute of Health and Care Excellence (2014) guidelines which demonstrate the efficacy of medication and its role in lessening symptoms. Among the participants in the study carried out by Lally and MacCabe (2015) the reductions in positive symptoms and improvements in functioning were recognised as important benefits of western bio-medical care (antipsychotic medication). Similar arguments have been made within the wider African context reflected in Nigerian studies by Abubakar et al. (2013) and Adelufosi et al. (2013b) where the improved quality of life of service users was associated with western medicine such as antipsychotic medication adherence.

Furthermore, as the research by Oyekanmi et al. (2012) suggest among Nigerian male outpatients their use of medication lessened their acute symptoms. However, they similarly argued that the majority did not return for follow-up and adherence to antipsychotics was poor, even among those who responded well to treatment, suggesting side effects as a reason for medication default. The presence of side effects among the participants' in Ibrahim et al. (2015) study was also associated with significant impairment in their quality of life as well as serving as a hindrance in their ability to carry out some activities of daily living. Similar to the finding in this current study those participants' who were noncompliant to their medication in that study among patients with schizophrenia had at least one side effect, the most challenging of which was its effect on sexual function.

This negative view of the side effect contributes significantly to non-adherence to western medicine among some African patients in Ghana (Read, 2012) and Ethiopia (Teferra et al. 2013). This was also the finding in Dodgen et al.'s (2015) South African study where western biomedical care had been used by the majority of participants in the symptomatic treatment of

schizophrenia such as controlling aggression or inducing sleep. However, in many cases in these studies western medicine had been discontinued, even where it had been recognised to have beneficial effects, due to the unpleasant side effects such as feelings of weakness and prolonged drowsiness.

There is a clash then between the perceived benefits of adhering to a western medicine and the lived reality that requires recognition of a social model. Whilst western medicine compliance may help as a step in the journey toward symptom control it becomes problematic when the men wish to take a further step in their recovery journey and reengage in expected social roles (including sexual performance and provider roles). Given the continued importance of sexual performance as a marker of African Masculinity (Barker and Ricardo 2005) and the pressure to function as the family head and financial provider highlighted in the current study, it is no surprise that many of the men expressed reservations about western medication compliance once the acute phase of illness had passed and the journey to recovery had begun.

This dilemma about side effects associated with the men's western bio-medical care resonates in the views of the health professionals. There seemed to be a recognition among the health professionals in this study that western medicine increases the likelihood of recovery in schizophrenia. In their exploration of psychiatrists' views of the benefits and risks of western medicine, Markowitz et al. (2014) similarly reports that the primary importance of acute interventions such as medication treatment is the resolution of symptoms. However, the importance placed on western medicine, had been challenged by risks of side effects, such as those reported within the literature and sexual dysfunction cited in this current study. This awareness of side effects risks within the data in this study, and those referred to with the

literature, meant that among the health professionals in this study, western medicines prescription were regularly reviewed during outpatient's clinics.

The use of western medicine for mental health problem by the men in this study is not influenced solely by the medication side effects. In this sense, whilst health professionals in this study often focused on a biological framework for understanding the onset of psychotic symptoms, the men relied on a social construction of their condition. In several instances, health professionals comments suggests that the biological risk of developing schizophrenia is higher among persons with an affected family member. Therefore, among the health professionals in this study their biological framework for understanding mental health problem is associated with genetic risk component. They further explained that this biological framework is in line with the bio-medical knowledge acquired during psychiatric training. As Magliano et al. (2013) demonstrated in their study which explored causal explanations for schizophrenia among medical students' in the University in Italy, where medical students' frequently cited heredity as biological cause of the condition which was explained as consistent with their medical education.

However, this tension in causal explanation and views about the onset of schizophrenia rolls over to the models of recovery, with health professionals' in this study focussing on western medicine, therefore keeping appointments and medications were seen as important, whereas the men themselves were more focused on "pragmatic embodiment" (Watson 2000), on maintaining a functioning body in everyday life that allowed them to fulfil gender specific roles and expectations. It is this discrepancy in focus that he claims is responsible, at least in part, for lack of success of western biomedical care. Perhaps it is against this backdrop that Sales

and Schlaff (2010) suggests that a more effective medical education should address professional training in the family and social milieu of the patient.

In addition to these, some of the men also talked about the difficulties in accessing these urban located hospital-based western medicine. This suggests that rural dwellers with mental health problems could perhaps lack appropriate mental healthcare as they would struggle to get to appropriate services. The problem expressed by these participants' associated with a longer distance of accessing western medicine, has been similarly identified by the health professionals in this study as a reason for patients missed hospital appointments. Therefore, the data in this study suggests that, although, some of men appreciate the need for western medicine, however there was the concern of patients not attending hospital appointments due to their inability to meet costs of travel for urban located western medicine.

The shortage of western medicine highlighted in this current study is similar to that reported by Cooper (2015) where post-colonial healthcare development in Nigeria often results from the fact that the majority of western medicine are located in urban areas, while the rural areas are mainly without such services. There is a problem with this disparity, key among this is that appropriate western medicine for mental health problems is frequently delayed because many of the men in this study often first seek help from traditional and religious healers. As will be discussed, traditional sources play complementary roles, however, its usage raises a concern that such patronage could be due to the lack of western medicine in the local community and patients' having to take whatever is available rather than seeking what they think would be the best treatment. Abdulmalik et al. (2013) discusses the treatment gap for western medicine in Nigeria, where the difficulties of accessing western medicine was found to influence

individuals' use of religion and traditional medicine. In another Nigerian study of health workers experience of providing mental health services, Jack-Ide, Uys and Middleton (2013) also found that patients who arrive at the psychiatric hospital in Port Harcourt had previously used traditional sources due to ease of accessibility. The reasons for use of traditional sources of help in schizophrenia then may be as much related to what is readily available as it is to beliefs about causation or treatment toward recovery.

The costs associated with uptake of western medicine by the men in this study is not only limited by travel costs. Even though, western medicines have been shown to improve symptoms associated with the condition, non-adherence to treatment is reported among the men in this study due to costs associated with anti-psychotic medication. As Meshach, King and Fulton (2014) point out among Nigerian individuals with mental health difficulties, the experience of poverty which resulted in lack of money to buy medication, or to meet transportation costs to the hospital or pharmacy, impacted negatively on use of western medicine. As the results of the Nigerian study by Effiong and Umoh (2015) also demonstrates, the majority of individuals in their study, were without a source of income and so, encountered much difficulty in purchasing their medication. However, this brings to light another problem about post-colonial western psychiatry in Nigeria relating to socio-economic circumstances of individuals and their willingness to take-up western psychiatry.

There were mixed views about the importance of western psychiatry. Whilst some highlighted how this medication brought about a lessening of symptoms the side effects associated with these medications – particularly on sexual function and the ability to focus and function at work - were also shown to have a significant impact on their willingness to continue with western



medication beyond the acute symptom phase. Western medicine then were said to play a role in the men's recovery, however, as will be discussed further there are alternatives (or additions) to this more clinical approach to recovery.

When the men in this study, further illustrate their perceptions and experiences, the significance of their religion, where prayer was viewed as a way to seek God's favour in their recovery from their mental health problem, emerged as important. This current work suggests that these men often place trust in an invincible figure and then they endowed the agency of their recovery to that Supreme Being or God. Pargament (2001) likened this type of religious coping to a deferring approach, where individuals take a relatively passive role in the resolution of their health difficulties, trusting God to help resolve the problem. Corwin's (2014) study which examines prayers as they are performed in Mass and in prayer groups at a Catholic convent in the United States of America, provides evidence in support of this sort of religious belief. The findings of that study similarly suggests that the function of this prayer was also to make request to the divine and to elicit God's aid in achieving wellbeing of those who are suffering from illness. A similar belief was reported by Krause (2014) where Pentecostal healing prayers among some Africans in the United Kingdom sought God's deliverance or even bestowed their recovery from mental health problems to God.

It seems no single reason offers a full explanation of the importance of religion in the context of health among the men in this current study. However, some held religious or spiritual causal beliefs, and this understanding of their mental health problem as a religious-spiritual condition meant religious-spiritual attention was required to facilitate and maintain recovery. This observation was illustrated in southwest Nigeria, in the study by Adewuya and Makanjuola

(2009) which explored preferred treatment among the community, where those with religious conceptualisation of mental health difficulties preferred involvement of the local church or mosque such as through prayers, while those who significantly endorsed spiritual causes of the condition often sought help from herbalist involving sacrifices and herbs. This finding is in line with the findings of Corwin's (2014) and Krause (2014) who indicated that prayers is a form of religious coping, although, this contrast with a further theme in Asamoah et al.'s (2014) study, relating to the financial role of clergy in meetings the healthcare needs of people with mental health difficulties. Among the clergy in Asamoah et al.'s (2014) Ghanaian study many expressed the view on the role of their churches in supporting people with mental health difficulties, where it emerged some of these religious leaders offer financial assistance.

Also, the acceptability of religion among the men in this study is related to availability. When exploring the reasons for the widespread use of religion and traditional sources in Ghana, it also emerged among the participants in Ae-Ngibise et al.'s (2010) study that the appeal of religious and traditional sources was related to the easy access to such practitioners' practicing in both rural and urban area. As the findings in Khoury et al.'s (2012) study of treatment-seeking pathways for mental health difficulties suggest, structural factors such as the scarcity of treatment resources created the greatest impediments to biomedical care for mental health concerns in rural Haiti. Related to this, in a Nigerian study, Adeponle et al. (2007) described how it is rare to find a street without at least a prayer house. However, it seems that service users who attend prayer centres relying on promises of miraculous healings, are sometimes being (implicitly rather than overtly) discouraged from the use of western medicine. As noted within the literature, problematically, after several visits to religious and traditional sources, some of the men in this study then resorted to western medicine by which time their condition had often worsened and become very acute. As Adeosun et al. (2013) found patients who first

consulted religious or traditional sources saw an average of about six care providers before presenting to mental health professionals, compared to an average of one care provider among those who first consulted a general practitioner. This delay has also been reported by Odinka et al (2015) who showed that religious and traditional sources were consulted as first contact, by many of the participants in their study. The exacerbation of the men's mental health condition, associated with delays in the initiation of appropriate treatment was also a concern shared by the health professionals in this current study. As the hospital staff explained it is not uncommon, for example, to find that many of these men who had initially relied on other sources for their mental health problem, eventually presenting to hospital emergency department in much worse conditions.

Just as some of the men provide accounts of their recovery being associated with prayers, or God being responsible for their recovery, others talked about their use of herbs reflecting the medicinal value of local plants. Evidence supporting this comes also from Nigerian studies such as those carried out by Awodele et al. (2013) and Lifongo et al. (2014) which examined plants used traditionally within these communities suggesting numerous varieties of medicinal plants. The varieties of medicinal plants in Nigerian communities referred to within the literature helps in understanding or even reflecting, the availability of traditional sources which the men in my study aligned themselves to. As with the discussion of religious-spiritual beliefs earlier, the reasons for use of traditional sources of help in schizophrenia among the men in this current study then may be as much related to the readily availability of these local plants. Therefore rather than viewing traditional sources as a (or even the) primary outcome of the men's causation belief, this current work highlighted the availability of traditional medicine as a defining feature to this model of recovery.

Although, it is suggested that using traditional models of recovery, rather than more biomedical western forms, is a consequence of availability, it is also important to acknowledge that the men provide contradictory constructions of herbal treatment when presenting their stories of recovery. This included instances, where many of the men talked about the not effective in addressing their mental health difficulties. This concern raised by the men about the utility of traditional medicine also surfaced by the health professionals in this study in relation to their concerns about the fact that there is a great diversity of traditional healers and moreover, there seems to be a lack of agreement amongst the numerous traditional healers on what constitutes evidence to guide their practice. The evidence from within the literature, also reflect concerns about the effectiveness of traditional medicine. Omoleke (2013) Nigerian study among traditional medicine practitioners, service users and western biomedical professionals within south-western part of the country, examined the relevance of the traditional medicine in health care delivery services in this community, where findings from the study suggest that the use of traditional medicine is widespread. However, there were concerns regarding its effectiveness.

There are therefore possible benefits associated with the men's use of religion and traditional sources. This then strengthens the likelihood of collaboration with mainstream mental health services. As Ae-Ngibise et al. (2010) Ghanaian study found whether we like it or not people are going to them. Also, the findings from Thomas et al.'s (2015) study in the United Arab Emirates, suggest that substantial investments in healthcare have ensured the widespread availability of medical services across the country. However, inspite of the availability of western medicine, the consultation of religious and traditional sources for mental health issues continue to play an important role in the healthcare of the people.

When these Nigerian participants' further illustrate the possibility of recovery, or at least a progress and journey towards this, their constructions highlight the family as a significant psychosocial resource and factor influencing recovery from mental health problems. When they talked about how the family contribute to their recovery, many suggested that they were accompanied by their relatives to mental health services. What emerges from this is seeing the family as an important connecting and facilitating link to healthcare. This could be what some of the health professionals in this study, meant about the role of the family where in their discussions emphasis is placed on the significance of relatives accompanying patients such as provision of information aiding western bio-medical care. A similar view emerged in the study by Adeosun et al. (2013b) among Nigerian outpatients where it was reported that relatives initiated much of the contact with health services. Alongside this, the majority of service users who attended for healthcare in their study were more likely to be accompanied for their first visits to hospital by relatives, aiding practitioners with information about their relative's mental health conditions.

The present findings lend support to this important influence of the family in contributing to mental health recovery through also aiding payments for their relative's western biomedical care. This contrasts to the National Health Service in the United Kingdom, for instance, where Department of Health (2015) guidelines stipulate that access to health services are free at the point of use. However, there is more involved with family support in Nigeria than just assistance with payment for treatment, in particular the role of the family in empowerment. As demonstrated, family interventions seem beneficial to relatives with schizophrenia recovery, through mechanisms such as through improved medication adherence reducing risk associated with illness relapse or rehospitalisation. The family, in this sense, is primarily an enabler or a facilitator empowering the individual to aid their recovery. Tengland (2008) discusses such

empowerment as a collaborative approach where those facilitated actively participate in the health-related change. In a total of 13 publications reviewed by Woodall et al. (2010) there is some evidence suggesting that empowerment approaches can improve health outcomes for both individual and community health.

Empowerment, as demonstrated in this current study, includes family intervention in actively facilitating their relative also in ways which significantly contribute to the men's recovery. For instance, among these men those who kept hospital appointments had their transport cost met or supplemented by their family. As Tengland (2012) suggests, if people are to move on from disabling situations, they may need support in changing their context from one in which they may feel stuck within their mental health problems to one in which they may feel more empowered and this has indeed been the case in the current study.

Although the participants' perceptions and experiences referred to in this study suggest that the concept of empowerment can be beneficial, there is also a concern that has been raised about the family empowerment approach. As the data revealed there can be significant disagreement over their family's choice of health service. In a few instances, family members with schizophrenia were taken to a traditional and religious source by their family rather than their preferred western medicine. This sort of discrepancy highlighted in this study, as well as those reported by Tengland (2010), indicate a difficulty with the empowerment approach in that a family enabler can also impose its method and goal on their relative – perhaps due to entirely understandable financial concerns or limitations. In this sense, empowerment options might only be available to those with the necessary financial resources to. Nonetheless empowerment,

as a principle, remains a central tenet of family involvement with the men in this current study demonstrating its importance in facilitating mental health recovery.

## 8.5 Limitations of the study

Although, the findings of this research addressed the aim of the study, one limitation is that it was conducted using one setting, with all the participants drawn from a psychiatric hospital within a local community in northern Nigeria. Therefore to generalise the results for larger groups, future study should involve more participants at different sites. Another potential limitation relates to the effect of not having any family members among the study sample. It seems that including families could have brought different perspectives. However, the considerable effort and time invested by the male patients who took part, and additional professional carers data, has generated new insights into how men were managing their recovery from mental health difficulties within northern Nigeria.

In this study, there are some effect related to using particular methods. As, the aim of current study sought understanding of men's management of mental health difficulties within a particular social context, Berger and Luckman's (1991) social construction of reality was adopted. Their central concept underlying this approach is that meaning is embedded in society. Reality is therefore socially constructed. In the process, knowledge and people's beliefs of what reality is then defined within socio-cultural context. The effect of this epistemological approach, is in defining the study population. As Ritchie et al. (2013) suggest to delineate a target population, a set of inclusion criteria or exclusion criteria, should specified an attribute that cases must possess to qualify for the study. In this research, the inclusion criteria specifies

that participants must be men previously diagnosed with schizophrenia, who are currently in contact with the psychiatric hospital and living within the Nigerian community.

The inclusion criteria or exclusion criteria aided the process of sampling. As Creswell (2014) point out the rationale for employing a purposive strategy is that the researcher assumes, based on their theoretical understanding of the topic being studied, that certain categories of individuals may have a unique, different or important perspective on the phenomenon in question and their presence in the sample should be ensured. For example, in my own research, this influenced the specific purposive sampling that included male outpatients recovering from mental health difficulties recruited from those who attend at the psychiatric hospital. Also, purposively recruiting hospital staff with experience of supporting the men, also, helped me gained useful insights about the service users' recovery through additional health professional data about how the men were managing their condition.

Recruiting participants within organisations can present particular challenges, however, I was aware of this hospital and had conducted a pre-site visit, when I obtained the provisional support of the hospital. This made accessing participants feasible. The effect of collecting data using interviews supported a conversation which gave the opportunities for the men to talk about their experience of recovery from mental health difficulties. To facilitate in-depth accounts of their perspectives, I adopted the stance of active listener, however, using probing questions and reflective statements arising from the participant's discussion to increase the depth of the data. An analytic framework based on Braun and Clark's (2006) identification of different themes was developed. The product of this analysis then was an interpretation relating to mental health recovery to make sense of their experience, and these were represented as



themes. Further analysis of these themes therefore illuminates the men's views about the social-contextually dependent nature of their recovery from mental health difficulties providing insight for practitioners and those involved in service or policy development.

On the question of whether the families should have been interviewed, or relating to how many interviews are enough in qualitative study, however, there is variability in what is suggested as a minimum within the literature. Even though, there is some uncertainty, a frequent reference for answering how many interviews are enough is the concept of theoretical saturation, whereby collecting more data does not add further themes. In this regard, during data analysis of my study, key themes emerged at an early stage after my exploration of the interview transcripts. This criterion is consistent with the findings in Guest, Bunce and Johnson's (2006) study. In that study, they carried out a systematic analysis of their own data from a study of sixty women, involving reproductive health care in two West African countries (Nigeria and Ghana). They examined the codes developed from their interviews, in an attempt to assess at what point their data were returning no new codes, and were therefore saturated. Their findings suggested that data saturation had occurred at a very early stage. Of the thirty six codes developed for their study, thirty four were developed from their first six interviews, and thirty five were developed after twelve. Their conclusion, was that "a sample of six interviews may be sufficient to enable development of meaningful themes and useful interpretations" (p.78). Examining 25 in-depth interviews, Hennink et al. (2016) also found that code saturation was reached at nine interviews, whereby the range of thematic issues was identified. However, 16 to 24 interviews were needed to reach meaning saturation where that developed a richly textured understanding of issues. Therefore, code saturation indicate when researchers have "heard it all," and this they argue links to meaning saturation which the author likened to situation of "understand it all." Furthermore, as Malterud et al. (2016) suggest information

power is about the notion of good informants. Therefore, as he argued rich data in qualitative studies depends on developing relevant conceptual issues that provides insights to the research questions rather than how many interviews.

## 8.6 Summary

The discussion in this chapter contributes to the understanding of the tensions that exist for men with schizophrenia in contemporary Nigeria. There are focussed onto three main areas, the conflict between traditional views relating to religion, superstition and Western medicine, the challenges faced by men living in the poor socio-economic environment of post-colonial Africa, and managing complex gender relations, which are founded on traditional views of men and their roles in a changing society.

In the first place, there emerged a tension between the men's beliefs and their health professionals views about the cause of mental health difficulties. The notion of the condition caused by the will of God, or through spirits possession, reflects the religious-spiritual beliefs among the men in current study. Linked to this, mental health problems identified as religious in origin were associated with the perceived need for a religious resolution of the condition. An implication of these beliefs is the increased likelihood of accessing care from religious leaders. With religion being of such significant importance among the lives of the men, it is not surprising to find their use of prayers as a religious coping mechanism where they sought God's help in aiding recovery from their mental health difficulties. The significance here relates to how some of the men believed that God had answered their prayers, evident in the relief of symptoms associated with their condition. However, for others, the symptoms persisted despite the use of prayers. Consequently, although lay beliefs about their mental

health difficulties are an important factor associated with treatment-seeking behaviour, religious coping was also associated with delaying of appropriate intervention such as medical treatment. The tension for the men is that such delays links to more serious consequences, such as worsening of symptoms associated with the onset of their mental health difficulties, which could have been treated with earlier engagement with mainstream medical interventions.

Having accessed care there was an importance in the men being able to adhere to western psychiatry such as the use of antipsychotic medications for the control of acute symptoms associated with their mental health difficulties over the longer term. However, a further critique of the post-colonial western psychiatry in Nigeria, relates to hospital-based services, which are often far located in urban areas, while the rural areas are mainly without such western medicine. This disparity in the availability of western psychiatry within modern day Nigerian health system means that often the access to mental healthcare is difficult for people living in rural areas, particularly for those living further away from towns or cities.

The practical reality of the lack of western psychiatry at local communities for the men with mental health difficulties in modern day Nigerian context, brings to light the important role that religion and traditional sources play in meeting the health needs of the communities. With the largely urban hospital-based western psychiatry, it is understandable the loss of individuals to alternative treatment practitioners who are relatively greater in number, more widely spread and hence more accessible in contrast to western psychiatry located further away. Also, this highlights the wider challenge facing mental healthcare in modern Nigeria, where the integration of western psychiatry into rural communities seems slow to action.

Another tension for the men with mental health difficulties in contemporary Nigerian context, as the findings of this study suggests, is that where medical treatments are accessed, it often involve longer travelling distance for rural dwellers. The problem is that the patients from rural areas were more likely to experience a high level of burden, compared with those from urban areas, which is because of the additional burden associated with travelling longer distances to access western psychiatry.

A further factor that was linked with this burden, was associated with the socio-economic circumstance of individuals. The disadvantaged living situations of some of these patients because of unemployment and poverty poses great challenges, to the utilisation of mainstream mental health services. While this dilemma, lends support to the important role the family plays in supporting the recovery of their relative, it also links to the wider evidence that emphasises the family burden of care among men with mental health difficulties within Nigerian community.

The discussion within this chapter also highlights the impact of gender on both the men's risk of developing schizophrenia and its influence on their recovery from the mental health difficulty. The pressures associated with the men's adherence to traditional gender views about being the head of the household and providing for the family needs, were cited as exacerbating the onset of the condition. This implies that social factors related to traditional male role expectations, is a tension that may be associated with acute episodes of schizophrenia among the men in northern Nigeria. However, at times and for some of the men in this study, the idea of gender flexibility was associated with a transformation of traditional gender expectations. Gender flexibility may help address the pressures associated with the traditional male provider role and aiding men's recovery within modern day Nigeria.

## CHAPTER NINE: SUMMARY OF FINDINGS AND CONCLUSION

### 9.1 Introduction

In the period of time, it took me to undertake the work required to complete this thesis much has happened related to men and their health in Nigeria. As Olabode, et al. (2014) suggests the number of projects addressing men's health, has grown through work in the United Nations Millennium Development Goals initiatives. However, despite such progress, an empirical research base around men's health, which takes into account the impact of gender highlighted in this current study continues to be slow to develop. It is therefore important to summarise as concisely as possible what the findings of this study illuminate in respect to the research questions, which sought to explore Nigerian participants' perceptions and experiences about the causes of schizophrenia, and the factors that influence its recovery. This chapter is split into three parts: The first part highlights the main points relating to how men construct their mental health problem. The second part looks at the data in relation to their understanding of health and recovery. The final section draws out the practical considerations that arise from this research and the implications for future policy and research.

### 9.2 Triggers exacerbating schizophrenia

The results presented show that when it came to understanding traditional views about the causes of mental health difficulties, there is a belief in a religious or supernatural link. In particular, the notion of God's will, ancestral spirits and Jinn possession being responsible for the condition emerged, including punishment by God due to a sin believed to have been committed by the person. Findings suggest that those who breach societal norms were seen as afflicted with mental illness as these actions offends God. Many of the men delayed seeking Western medical help as local religious or traditional healing was attempted. As discussed

earlier, this finding reinforces those of previous studies in relation to religious and supernatural beliefs in the onset of mental health difficulties within the African context.

The beliefs about cause of schizophrenia is not limited to religious views, as shown, a biological causal factor also emerged. In particular, the current study conceptualised a biological cause of the condition in terms of genetic risk factor. Genetic heritability of schizophrenia as data revealed, involves a biological process through which individuals' are believed to acquire at birth, and therefore are born with certain vulnerabilities to mental health condition.

However, the finding of this study, highlight the impact of traditional gender as a risk factor exacerbating schizophrenia. This was illustrated for example, through these men feeling they should be head of the household. This was shown to be a traditional view of gender where the establishment of a household by being married, becoming a husband and father children, facilitates the status of being head of family. Within this concept of the male being head of the family, a man was also expected to find employment or start a business to raise money for the financial expectations associated with being head of a family.

In particular, the pressure for a man as head of the household to oversee their family well-being in the current study, included references to their provision of accommodation, food, and clothing, meeting children's education in terms of school fees and school requirements, and the family health care needs. However, it was evident from the study that the men's risk of

developing schizophrenia, was associated with the pressure of living up to these traditional gender expectations and consequent shame and ridicule if they failed.

### 9.3 Turning points to recovery

The main findings presented in the thesis highlight the influence of western psychiatry, religion and family support on recovery. However, a key feature, which emerged from the study, is the significance of gender flexibility in the men's recovery. The presence of gender flexibility within the household reflects a broader understanding of the changing nature of men and women's roles within the modern African context. Implicit in this transformation were views that indicate that gender is not a fixed concept, but that it is dynamic and changes over time. The idea of gender flexibility emerging is that household members were embracing an alternative model of gender relations, in contrast to traditional gender, where there is pressure for a man as head of the household to oversee their family needs.

In providing data, which associates gender flexibility with opportunities for sharing responsibility, the current study makes a unique contribution to new knowledge by highlighting the link between gender and the men's ability to become involved in their recovery from mental health difficulties. This new flexibility in gender, where household members crossed traditional fixed notions of gender expectations, was significant for the men in this study in creating new spaces to help the recovery process.

## 9.4 Study implications

Having considered the main contributions to knowledge that this thesis makes, it remains to highlight the potential significance of these findings for practice, future policy and research.

### 9.4.1 Implications of findings for healthcare practice

This study provides insights into concepts of being a man among the participants' in a community within northern Nigeria. The traditional views of gender, specifically, notions of hegemonic fatherhood highlighted by the data in this study, revealed male provider expectations around the domestic roles. It is important for those involved in their care to understand how traditional gender expectations can be a trigger that exacerbates onset of acute schizophrenic episodes. However, as discussed earlier, these traditional expectations of fatherhood are changing within modern Africa, with an emerging gender flexibility in household practice.

Consequently, these findings could offer those involved in their care extended or alternative understandings, with implications for the men's recovery. In particular, the findings of this study can contribute to informing mental health professionals practice in designing health interventions for the men. Therefore, there is the need for gender educational awareness programmes for the men and those involved in their care.

Gender transformative programs are required to engage participants in discussion relevant to facilitating change in traditional gender expectations around men and women's roles in society and to promote more gender equitable relations between men and women. Barker, Ricardo and Nascimento (2007) and Ricardo, et al. (2010) provide evidence of similar work being carried



out in Brazil by Promundo, a non-governmental organisation based in Rio de Janeiro in collaboration with other partners like the World Health Organisation, aimed at gender equality.

#### 9.4.2 Implications of this study for health policy

The finding presented in this thesis have shown that the costs associated with western medicine presents a huge burden for the male service users and their family. It was evident in the accounts provided by the participants that within the current Nigeria health system payments are required before healthcare are administered to a service user. In addition, there were costs associated with medication purchase and travelling to access western medicine. This highlights the need for the development of policy by Ministry of Health aimed to subsidise costs associated with the services users' western medicine uptake. Similar concessions are successfully done in the United Kingdom. For instance, those with mental health problems do qualify for travel concessions and provided with a free travel card (Office of Public Sector Information, 2000).

The treatment gap highlighted in this study where the majority of hospital-based nature of western medicine are far located in urban areas, while the rural areas are mainly without such services reinforces the need for scaling up mental health care in Nigeria. Integrating mental health services into primary care is a viable way of closing the treatment gap and ensuring that people get the mental healthcare they need.

Linked to this, the study findings also have implications for the development of policy using the World Health Organisation's (2011) mental health gap intervention guide to get traditional/faith healers to understand mental health problems identification, treatment, and

referral. A similar work by Hills, et al. (2013) in East London, which explored mental health practice by African traditional healers, found that such framework contributed to collaboration with religious healers accepting the treatment guide provided by biomedical professionals.

#### 9.4.3 Implications of the study for future research

The data in the study is unique in the masculinities and health field in highlighting the link between gender and men's recovery from schizophrenia in a community within northern Nigeria. Although, as noted earlier, the sample size was influenced by what was considered appropriate for a qualitative research and the findings are consistent with previous studies. A study limitation was that the findings could not be generalised to the entire population of Nigeria. To address this, there is need for further research.

Future research is needed in Nigeria and the wider African context to explore in more detail what aspects of gender can influence service users' views about the onset of their schizophrenia. Another area that need further research and consideration is the role of gender in promoting men's views about their recovery. Multi-centre studies could be conducted along the three major languages represented by Hausa of north, Yoruba of south-west and Igbo of south-eastern Nigeria. It is essential that further research be carried out across areas to develop further knowledge of gendered expectations and its impact. Such research is necessary so that the theoretical base of gender, schizophrenia and recovery can be further understood.

In the context of the United Kingdom, the largest population of Nigerians is found in the capital city, London. Peckham in south-London is now home to the largest overseas Nigerian

community in the United Kingdom (Office for National Statistics, 2012). The current study in the Nigerian context, associates the changing nature of gender in modern African setting with men's recovery from schizophrenia. Therefore, not only is further research needed within the wider African context, there is a need to explore in more detail in the United Kingdom, the impact of gender as a factor in schizophrenia and its recovery.

## 9.5 Conclusion

This thesis has strengthened the evidence base of previous knowledge about the impact of traditional masculinity on men's perceptions and experience of mental health problem. The participants commented on the pressures of traditional gender expectations, as a trigger exacerbating schizophrenic episode. However, the thesis has presented new evidence and discussion that asserts how society is changing as well as attitudes towards traditional male provider roles. In particular, the presence of gender flexibility within the household signify the occurrence of a transformation in men and women roles reflecting opportunities for emancipation of women in society. As discussed earlier, the shift towards gender equality also provide insights into the link between gender and men's management of their recovery from mental health difficulties in modern Africa.

## REFERENCES

- Abiama, E. and Ifeagwazi, M. (2015) The influence of burden of care and gender on mental health of caregivers in Uyo, Nigeria. **Journal of Humanities and Social Science**, 20(5), pp.67-72.
- Abubakar, K., et al. (2013) Prescription pattern of antipsychotic drugs: A case study of a neuro-psychiatric Hospital in north-western Nigeria. **European Journal of Scientific Research**, 95(3), pp.332-337.
- Achebe, C. (1958) **"Things Fall Apart"**. London, Heinemann.
- Adekunle, O. D. (2014) Old wine in new bottle: elements of Yoruba culture in Aladura christainity. **Black Theology**, 12(1), pp.19-32.
- Adepoju, J. A. (2012) A study of health beliefs and practices of the Yoruba. **Journal of Cultural Diversity**, 19(2), pp.36-43.
- Addis, M. and Mahalik, J. (2003) Men, masculinity and the contexts of help seeking. **American Psychologist**, 58, pp.5-14.
- Addis, M. E., Mansfield, A. K. and Syzdek, M. R. (2010) Is "masculinity" a problem? Framing the effects of gendered social learning in males. **Psychology of Men and Masculinity**, 11, pp.77-90.
- Adefolaju, T. (2011) The dynamics and changing structure of traditional healing system in Nigeria. **International Journal of Health Research**, 4(2), pp.99-106.
- Adekson, M. O. (2003) **Yoruba Traditional Healers of Nigeria**. London, Routledge.
- Adegoke, T. G. (2007) 'Socio-cultural factors influencing the use of spiritual healing churches in Ibadan Metropolis, Nigeria', **Anthropologist**, 9(3), pp. 225-232.
- Adelufosi, A. O., et al. (2012) Medication adherence and quality of life among Nigerian out-patients with schizophrenia. **General Hospital Psychiatry**, 34, pp.72-79.
- Adelufosi, A., et al. (2013a) Does religiosity influence attitude to mental illness?: a survey of medical students in a Nigerian University. **Journal of Behavioral Health**, 2(2), pp.135-139.
- Adelufosi, A. O., et al. (2013b) Socio-demographic and clinical correlates of subjective quality of life among Nigerian outpatients with schizophrenia. **Psychiatry Research**, 209, pp.320-325.
- Adeosun, I., et al. (2013a) The pathways to the first contact with mental health services among patients with schizophrenia in Lagos, Nigeria. **Schizophrenia Research and Treatment**, 1, pp.1-9.

Adeosun, I. I. (2013b) Correlates of caregiver burden among family members of patients with schizophrenia in Lagos, Nigeria. **Schizophrenia Research and Treatment**, 2, pp.1-8.

Adeponle, A., et al. (2009a) Prospective study of psychiatric follow-up default and medication compliance after discharge at a psychiatric hospital in Nigeria. **Community Mental Health Journal**, 45, pp.19-25.

Adeponle, A., et al. (2009b) Family participation in treatment, post-discharge appointment and medication adherence at a Nigerian psychiatric hospital. **British Journal of Psychiatry**, 194(1), pp.86-87.

Adeponle, A., et al. (2007) Missed first appointments: prevalence and associated factors in first-time attendees at an out-patient psychiatric clinic in Nigeria. **Mental Health, Religion and Culture**, 106, pp.609-620.

Adeponle, A., Whitely, R. and Kirmayer, L. (2012) Recovery in cultural context. In: Rudnick, A. (Ed.): **Recovery of People with Mental Illness**. Oxford, Oxford University Press, pp.109-132

Adewuya, A. O. and Makanjuola, R. O. (2008a) Lay beliefs regarding causes of mental illness in Nigeria: pattern and correlates. **Social Psychiatry and Psychiatric Epidemiology**, 43(4) pp.336-41.

Adewuya, A. O. and Makanjuola, R. O. (2008b) Social distance towards people with mental illness in south western Nigeria **Australian and New Zealand Journal of Psychiatry**, 42, pp.389-395.

Adewuya, A. O. and Makanjuola, R. O. (2009a) Preferred treatment for mental illness among Southwestern Nigerians. **Psychiatric Services**, 60, pp.121-124.

Adewuya, A. O. and Makanjuola, R. O. (2009b) Subjective quality of life of Nigerian schizophrenia patients: socio-demographic and clinical correlates. **Acta psychiatrica scandinavica**, 120, pp.160-164.

Adewuya, A. O. and Makanjuola, R. O. (2010) Subjective life satisfaction and objective living conditions of patients with schizophrenia in Nigeria. **Psychiatric services**, 61(3), pp.314–16.

Adewuya, A. O., et al. (2009) Prevalence and correlates of poor medication adherence amongst psychiatric out-patients in south-western Nigeria. **General hospital psychiatry**, 31, pp.167-174.

Abdulmalik, J., et al. (2013) Country contextualization of the mental health gap action programme intervention guide: a case study from Nigeria. **PLoS Med**, 10(8), pp.1-8.

Ae-Ngibise, K., et al. (2010) "Whether you like it or not people with mental problems are going to go to them": a qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. **International Review of Psychiatry**, 22(6), pp.558-567.

Ae-Ngibise, K., et al. (2015) The experience of caregivers of people living with serious mental disorders: a study from rural Ghana. **Global Health Action**, 8, pp.1-9.

Afe, A. E. (2009) Chieftancy institution and traditional taboo in south western Nigeria. **Current Research Journal of Social Science**, 1(1), pp.6-9.

Afe, A. E. (2013) Taboos and the maintenance of social order in old Ondo province South Western Nigeria. **Multidisciplinary Journal**, 7(1), pp.95-109.

Afolayan, J. A., Peter, I. O. and Amasueba, A. N. (2010) Prevalence of schizophrenia among patients admitted into neuro-psychiatric hospital Nigeria. **Continental Journal of Nursing Science**, 2, pp.8-16.

Agadjanian, V. (2005) Men doing women's work: masculinity and gender relations among street vendors in Maputo Mozambique. In: Ouzgane, L. and Morrell, R. (Eds.): **African Masculinities: men in Africa from the late nineteenth century to the present**. New York, Palgrave Macmillan, pp.189 – 203

Agbir, T. M., et al. (2010) Gender and psychiatric diagnosis: a 5-year retrospective study in a Nigerian Federal Medical Centre. **Nigeria Journal of Medicine**, 19(4), pp.455-458.

Aghukwa, C. N. (2012) Care seeking and beliefs about the cause of mental illness among Nigerian psychiatric patients and their families. **Psychiatric Services**, 63(6), pp.616-618.

Aigbiremolen, A. O. et al (2014) 'Primary Health Care in Nigeria: From Conceptualization to Implementation. **Journal of Medical and Applied Biosciences**, 6(2), pp. 35-43.

Alejandra, C., et al. (2015) The relationships between patients' and caregivers' beliefs about the causes of schizophrenia and clinical outcomes in Latin American countries. **Psychiatry Research**, 229(1), pp.440-446.

Aloba, O. O., Mapayi, B. M. and Adesanmi, A. O. (2014) Insight into illness in a sample of Nigerian patients with schizophrenia: sociodemographic and clinical correlates. **Ife psychologia: an International Journal**, 22(1), pp.80-91.

Akomolafe, A. C. (2012) 'Decolonizing the notion of mental illness and healing in Nigeria, West Africa', **Critical Psychology in Changing World** 1, pp. 726-740.

American Psychiatric Association (2013). **Diagnostic and Statistical Manual of Mental Disorders DSM-V**. USA, American Psychiatric Association.

Ammani, A. (2012) An assessment of the impact of exchange rate deregulation and structural adjustment programme on cotton production and utilization in Nigeria. **Trends in Agricultural Economics**, 5(1), pp.442-446.

Amoo, G. and Fatoye, F. O. (2010) Aggressive behaviour and mental illness: a study of in-patients at Aro Neuropsychiatric Hospital, Abeokuta. **Nigerian Journal of Clinical Practice**, 13(3), pp.351-355.

Amoo, G. and Ogunlesi, A. O. (2005) Financial cost of treating Nigerian in-patients with schizophrenia. **African Journal of Medicine and Medical Sciences**, 34(1) pp.15-23.

Ampofo, A. and Boateng, J. (2011) Multiple meanings of manhood among boys in Ghana. In: Tamale, S. (Ed.): **African Sexualities**. Cape Town, Pambazuka, pp.50-70.

Anderson, E. (2005) Orthodox and inclusive masculinity: competing masculinities among heterosexual men in a feminized terrain. **Sociological Perspectives**, 48, pp.337-355.

Andresen, R., Oades, L. and Caputi, P. (2003) The experience of recovery from schizophrenia: towards an empirically-validated stage model. **Australian and New Zealand Journal of Psychiatry**, 37, pp.586-594.

Anyan, F. (2013) The influence of power shifts in data collection and analysis stages: a focus on qualitative research interview. **The Qualitative Report** 18, pp. 1-9.

Appleton, P., et al. (2012) Understanding global sexualities: new frontiers. In: New York, Routledge, Arnfred, S. ed. (2004) **Rethinking sexualities in Africa**. Uppsala, Nordiska Afrikainstitutet.

Arthur, S. and Nazroo, J. (2003) Designing fieldwork strategies and materials. In: Ritchie, J. and Lewis, J. (Eds.): **Qualitative research practice: a guide for social science students and researchers**. Thousand Oaks, Sage,

Arowolo, D. and Aluko, F. (2010) Women and political participation in Nigeria. **European Journal of Social Sciences** 14 (4), pp. 582-593.

Ascher-Svanum, H., et al. (2006) Medication adherence and long-term functional outcomes in the treatment of schizophrenia in usual care. **Journal Clinical Psychiatry**, 67, pp.453-60.

Arias, D., et al. (2016) Prayer Camps and Biomedical Care in Ghana: Is Collaboration in Mental Health Care Possible?, **PloS One**, 11(9), pp. 1-16.

Asamoah, M. K. et al (2014) The role of Pentecostal clergy in mental health-care delivery in Ghana, **Mental Health, Religion and Culture**, 17(6), pp. 601-614.

Asiyanbola, A. (2005). **Patriarchy, male dominance, the role and women empowerment in Nigeria**. International union for the scientific study of population conference. France, July 18-23.

Asiyanbola, R. A. (2001). **Variations in masculinity, gender roles and physical well being of men and women in the family: a preliminary survey in Ibadan Nigeria.** *Gender, Population and Development in Africa*. Abidjan, 16th – 21st July.

Askey, R., et al. (2009) What do carers of people with psychosis need from mental health services? exploring the views of carers, service users and professionals. **Journal of Family Therapy**, 31, pp.310-331.

Atilola, O. and Olayiwola, F. (2010) Pattern of psychiatric inpatient admission in Ibadan: implications for service organisation and planning. **Annals of Ibadan Postgraduate medicine**, 8(2), pp.106-110.

Atindanbila, S. and Thompson, C. E. (2011) The role of African traditional healers in the management of mental challenges in Africa. **Journal of Emerging Trends in Educational Research and Policy Studies**, 2(6), pp.457-464.

Audu, I., et al. (2011) Stigmatization of people with mental illness among inhabitants of a rural community in northern Nigeria. **International Journal of Social Psychiatry**, 59(1), pp.55-60.

Awad, A. G. and Voruganti, L. N. (2008) The burden of schizophrenia on caregivers: a review. **Pharmacoeconomics**, 26(2), pp.149-62.

Awodele, O., et al. (2013) Traditional medicinal plants in Nigeria: remedies or risks. **Journal of Ethnopharmacology**, 150(2), pp.614-618.

Ayenibiowo, K., et al. (2012) Young adults perception of appropriateness of some domestic/home-related activities: implications for gender role acquisition. **Gender and Behaviour**, 10(2), pp.4767-4791.

Babalola, S. J. and Akor, M. (2013) An empirical analysis of labour force participation of married women in Adamawa State Nigeria. **Journal of Emerging Trends in Economics and Management Sciences**, 4(1), pp.1-7.

Bagasra, A. and Mackinem, M. (2014) An exploratory study of American Muslim conceptions of mental illness. **Journal of Muslim Mental Health**, 8(1), pp.57-76.

Banjo, A. D., et al. (2003) An ethno-zoological survey of insects and their allies among the Remos (Ogun State) south western Nigeria. **Indiling a African Journal of Indigenous Knowledge System**, 2, pp.61-68.

Barker, G. (2005) **Dying to be men: youth, masculinity and social exclusion**. London Routledge



Baker, S. E. et al. (2012) *How many qualitative interviews is enough?: Expert voices and early career reflections on sampling and cases in qualitative research.*, London: National Centre for Research Method.

Barker, G. and Ricardo, C. (2005) **Young men and the construction of masculinity in sub-Saharan Africa: implications for HIV/AIDS, conflict and violence.** Washington:DC, World Bank.

Barker, G., Ricardo, C. and Nascimento, M. (2007) **Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions.** Geneva, World Health Organization.

Barkhof, E., et al. (2012) Interventions to improve adherence to antipsychotic medication in patients with schizophrenia. **European Psychiatry**, 27, pp.9-18.

Bauer, S. M., et al. (2011) Culture and the prevalence of hallucinations in schizophrenia. **Comprehensive Psychiatry**, 52(3), pp.319-325.

Bazeley, P. and Jackson, K. (2013) **Qualitative data analysis with NVivo.** 2 ed. Thousand Oaks, Sage.

Beaglaioich, C., Sarma, K. and Morrison, T. (2013) New directions in gender role conflict. In: Gelfer, J. (Ed): **Masculinities in a global era**, New York, Springer, pp.17-52.

Beauchamp, T. and Childress, J. (2001) **Principles of biomedical ethics** 5ed. Oxford, Oxford University Press.

Bella, T., et al. (2012) Perceptions of mental illness among Nigerian adolescents. **International Journal of Culture and Mental Health**, 5(2), pp.127-136.

Berg, B. and Howard, J. (2014) **Qualitative research methods for the social sciences.** New York, Pearson.

Betty, S. (2005) The growing evidence for 'demonic possession': what should psychiatry's response be? **Journal of Religion and Health**, 44, pp.13-30.

Bhati, M. (2013) Defining psychosis: the evolution of DSM-5 schizophrenia spectrum disorders. **Current Psychiatry Reports**, 15(11), pp.1-7.

Bleuler, E. (1950) **Dementia praecox or the group of schizophrenias.** New York, International universities press.

Bojuwoye, O. (2013) Integrating principles underlying ancestral spirits belief in counseling and psychotherapy. **Ife Psychologia**, 21(1), pp.75-90.

Bottorff, J., et al. (2011) Gender relations and health research: a review of current practices. ***International Journal for Equity in Health***, 10(60), pp.1-8.

Boutillier, C., et al. (2011) What does recovery mean in practice? a qualitative analysis of international recovery-oriented practice guidance. ***Psychiatric Services***, 62(12), pp.1470-1476.

Bourke, B. (2014) Positionality: Reflecting on the Research Process. ***The Qualitative Report***, 19(33), pp. 1-9

Bouwman, C., et al. (2015) Employment and the associated impact on quality of life in people diagnosed with schizophrenia. ***Neuropsychiatric Disease and Treatment***, 11(2125), pp.2125-2141.

Bowles, H. R. (2012) Psychological perspectives on gender in negotiation. In: Ryan, M. and Branscombe, N. (Eds.): ***The Sage Handbook of Gender and Psychology***. Thousand Oaks, Sage, pp.465-483

Boyatzis, R. (1998) **Transforming qualitative information: thematic analysis and code development**. London, Sage.

Brannon, R. and David, D. (1976) The male sex role: Our culture's blueprint for manhood and what it's done for us lately. In: Davis, D. and Brannon, R. (Eds.): ***The forty-nine percent majority: The male sex role***. Reading, MA., Addison-Wesley,

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. ***Qualitative Research in Psychology***, 3, pp.77-101.

Braun, V. and Clarke, V. (2013) **Successful qualitative research: a practical guide**. London, Sage.

Breitborde, N. J., et al. (2009) Emotional over involvement can be deleterious for caregivers' health: Mexican Americans caring for a relative with schizophrenia. ***Social Psychiatry and Psychiatric Epidemiology***, 44(9), pp.716-723.

Brown, C. and Lloyd, K. (2001) Qualitative methods in psychiatric research. ***Advances in Psychiatric Treatment***, 7(5), pp.350-356.

Bridges, T. and Pascoe, C. J. (2014) Hybrid masculinities: New directions in the sociology of men and masculinities. ***Sociology Compass*** 8(3), pp.246-258.

Bryman, A. (2012) **Social research methods**. 4 ed. Oxford, Oxford University Press.

Bulbulia, T. and Laher, S. (2013) Exploring the role of Islam in perceptions of mental illness in a sample of Muslim psychiatrists based in Johannesburg. ***South African Journal of Psychiatry***, 19(2), pp.52-54.

Burns, J. K. and Tomita, A. (2015) Traditional and religious healers in the pathway to care for people with mental disorders in Africa: a systematic review and meta-analysis. ***Social Psychiatry and Psychiatric Epidemiology***, 50(6), pp.867-877.

Burns, J. K. and Esterhuizen, T. (2008) Poverty, inequality and the treated incidence of first-episode psychosis. ***Social Psychiatry and Psychiatric Epidemiology***, 43(4), pp.331-335.

Burns, J., Jhazbhay, K. and Emsely, R. (2011) Causal attributions, pathway to care and clinical features of first-episode psychosis. ***International Journal of Social Psychiatry***, 57(5), pp.538-545.

Campbell, E., et al. (2015 ) Assessment of functioning among Nigerians with schizophrenia in a tertiary health facility. ***Journal of Psychosocial Rehabilitation and Mental Health***, 2(1), pp.35-41.

Caquero-Urizar, A., et al. (2014) An updated review on burden on caregivers of schizophrenia patients. ***Psicothema***, 26(2), pp.235-243.

Carers UK (2010) **Tipping point for care time for a new social contract**. London, Carers UK.

Carrigan, T., Connell, B. and Lee, J. (1985) Toward a new sociology of masculinity. ***Theory and Society*** 14(5), pp.551-604

Chien, W. T., et al. (2013) Current approaches to treatments for schizophrenia spectrum disorders: psychosocial interventions and patient-focused perspectives in psychiatric care. ***Neuropsychiatric Disease and Treatment***, 9, pp.1463-1481.

Chuku, G. (2015) ***Igbo women and economic transformation in southeastern Nigeria, 1900-1960***. New York: Routledge.

Clarke, K. and Couchman, G. (2012) Caregiver causal attributions in youth psychosis. ***Early Intervention in Psychiatry***, 6(3), pp.309-316.

Cogneau, D. and Moradi, A. (2014) Borders that divide: education and religion in Ghana and Togo since colonial times. ***Journal of Economic History***, 74(3), pp.695-729.

Connell, R. (2012) Gender, health and theory: conceptualizing the issue, in local and world perspective. ***Social Science and Medicine***, 75, pp.1675- 1683.

Connell, R. W. (2005) **Masculinities**. 2nd ed. Cambridge, Polity Press.

Cooper, S. (2015) Prising open the black box: an epistemological critique of discursive constructions of scaling up the provision of mental health care in Africa. ***Health***, 19(5), pp.523-541.

Cooper, D. (1967) *Psychiatry and Anti-psychiatry*. USA: Routledge

Cornwall, A. (2003) To be a man is more than a day's work: shifting ideals of masculinity in Ado- Odo, Southwestern Nigeria. In: Lindsay, L. and Miescher, S. (Eds.): ***Men and masculinities in modern Africa*** Portsmouth, Heinemann, pp.12-30

Cornwall, A. ed. (2005) **Readings in gender in Africa**. Oxford, James Currey.

Courtenay W.H (2000) Constructions of masculinity and their influence on men's well-being: a theory of gender and health. **Social Science and Medicine** 50(10), pp.1385-1401

Corwin, A. (2014) Lord, hear our prayer: prayer, social support, and well-being in a Catholic Convent. **Journal of Linguistic Anthropology** 24(2), pp.174-192.

Crabb, J., et al. (2012) Attitudes towards mental illness in Malawi: a cross-sectional survey. **BMC Public Health**, 12, pp.541-9.

Creswell, J. (2014) **Research design: qualitative, quantitative and mixed methods approaches**. 4 ed. London, Sage.

Dahlback, E., et al. (2003) I am happy that God made me a boy: Zambian adolescent boys' perceptions about growing into manhood. **African Journal of Reproductive Health.**, 7(1), pp.49-62.

Danladi, J., et al. (2013) Pharmaceutical care and medication adherence in management of psychosis in a Nigerian tertiary hospital. **Journal of Research in Pharmacy Practice**, 2(2), p.83.

David, D. and Brannon, R. eds. (1976) **The Forty-nine Percent Majority: the male sex role**. Reading,MA, Addison-Wesley.

Day, R., et al. (1987) Stressful life events preceding the acute onset of schizophrenia: a cross-national study from the World Health Organisation. **Culture Medicine and Psychiatry.**, 11(2), pp.123-205.

Deacon, B. (2013) The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. **Clinical Psychology Review**, 33, pp.846-61.

Deegan, P. (1988) Recovery: the lived experience of rehabilitation. **Psychosocial Rehabilitation Journal**, 11(4), pp.11-19.

Dein, S. (2004) Working with patients with religious beliefs. **Advances in Psychiatric Journal**, 10, pp.287-298.

Dein, S., Alexander, M. and Napier, D. A. (2008) Jinn, psychiatry and contested notions of misfortune among East London Bangladeshi's. **Transcultural Psychiatry**, 45, pp.31-55.

Demoz, Z., et al. (2014) Medication adherence and its determinants among psychiatric patients in an Ethiopian referral hospital. **Patient Preference and Adherence**, 8(1329-1335).

Denzin, N. (2009) **The research act: a theoretical introduction to sociological methods**. Englewood Cliffs, Prentice Hall.

Department of Health (2015) NHS Constitution for England. England, Department of Health.

Dodgen, T. M., et al. (2015) Risperidone-associated adverse drug reactions and CYP2D6 polymorphisms in a South African cohort. ***Applied and Translational Genomics***, 5(40-46).

Diaz, V. A. and Close, J. D. (2010) *Male Sexual Dysfunction*. **Primary care**, 37(3), pp.473-489.

Dixon, A., et al. (2006) Financing mental health services in low- and middle-income countries. **Health Policy and Planning**, 21(3), pp.171-182.

Duthé, G. et al. (2016) Mental health and urban living in sub-Saharan Africa: major depressive episodes among the urban poor in Ouagadougou, Burkina Faso, ***Population Health Metrics***, 14(1), pp.1-10

Eagly, A. (2009) The his and hers of prosocial behaviour: an examination of the social psychology of gender. **American Psychologist**, 64(8), pp.644-665.

Eagly, A. and Wood, W. (2012) Social role theory. In: Lange, P., Kruglanski, A. W. and Higgins, E. T. (Eds.): **Handbook of theories in social psychology**. Thousand Oaks, Sage, pp.458-476

Eaton, J., et al. (2015) Mental health care for vulnerable people with complex needs in low-income countries: two services in West Africa. **Psychiatric Services**, 66, pp.1015-1017.

Eboiyehi, F. A. et al. (2016) In Their Husbands' Shoes: Feminism and Political Economy of Women Breadwinners in Ile-Ife, Southwestern Nigeria. ***Journal of International Women's Studies***, 17(4), pp. 102-121.

Eduah, G. (2014) ***The Impact of the World Bank's SAP and PRSP on Ghana: Neoliberal and Civil Society Participation Perspectives***. University of Ottawa, Canada.

Edwards, S. D. (2011) A psychology of indigenous healing in South Africa. ***Journal of Psychology in Africa***, 21, pp.335-348.

Edwards, S. D., et al. (2011) Ancestral consciousness among the Zulu - A Wilberian perspective. **Journal of Psychology in Africa**, 21, pp.131-138.

Effiong, J. H. and Umoh, K. A. (2015) 'Medication Non Adherence in Schizophrenia: Prevalence and Correlates among Outpatients in a Tertiary Healthcare Facility in Uyo, South-South Nigeria', ***Clinical Medicine and Diagnostics***, 5(6), pp. 107-113.

Egbucha, G. C. (2006) Tradition and change in gender discrimination in family inheritance in Igboland. **Journal of Women Academics**, 1(1), pp.88-100.

Eisler, R. and Skidmore, J. (1987) Masculine gender role stress: scale development and component factors in the appraisal of stressful situations. **Behaviour Modification**, 11(123-136).

Eisler, R. M. (1995) The relationship between masculine gender role stress and men's health risk: The validation of a construct. . In: Levant, R. F. and Pollack, W. S. (Eds.): **A new psychology of men**. New York, Basic Books, pp.207-225

Elble, R. J. (2009) Clinical features, pathophysiology, and treatment. **Neurologic clinics**, 27, pp.679-695.

Elebuibon, Y. (2000) **The healing power of sacrifice**. Brooklyn, NY, Henrietta Press.

Engel, G. (1977) The need for a new medical model: a challenge for biomedicine. **Science**, 196, pp.129-136.

Esan, O. and Fawole, O. (2013) Comparison of the profile of patients with acute and transient psychotic disorder and schizophrenia in a Nigerian Teaching Hospital. **The Journal of Neuropsychiatry and Clinical Neurosciences**, 25(4), pp.327-334.

Esterberg, M. L. and Compton, M. T. (2006) Causes of schizophrenia reported by family members of urban African American hospitalized patients with schizophrenia. **Comprehensive Psychiatry**, 47, pp.221-226.

Evans, A. (2014) Women can do what men can do: the causes and consequences of growing flexibility in gender divisions of labour in Kitwe Zambia. **Journal of Southern African studies**, 40(5), pp.981-998.

Ezenduka, C., Hyacinth, I. and Ogbonnia, O. (2012) Estimating the costs of psychiatric hospital services at a public health facility in Nigeria. **Journal of Mental Health Policy and Economics**, 15(3), pp.139-148.

Fanon, F. (1963) *The Wretched of the Earth*. New York: Grove Press.

Fearon, P., et al. (2006) Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the AESOP Study. **Psychological Medicine**, 36(1541-1550).

Federal Ministry of Health (1991) **National Mental Health Policy in Nigeria**. Lagos, Federal Ministry of Health.

Federal Republic of Nigeria (2006) **National Gender Policy**. Abuja, Federal Ministry of Women Affairs and Social Development.

Frank, A. W. (1995) **The wounded story teller: body, illness and ethics**. Chicago, Chicago University Press.

Frankema, E. (2012) The origins of formal education in sub-Saharan Africa: was British rule more benign? **European Review of Economic History**, 16, pp.335-355.

Freeman, D., et al. (2013) Patients' beliefs about the causes, persistence and control of psychotic experiences predict take-up of effective cognitive behaviour therapy for psychosis. **Psychological Medicine**, 43(2), pp.269-277.

Freimuth, V. S., et al. (2001) African-Americans' views on research and the Tuskegee Syphilis Study. **Social Science and Medicine**, 52(797-808).

Funk, M., et al. (2005) Framework for mental health policy, legislation and service development: addressing needs and improving services. **Harvard Health Policy Review**, 6(2), pp.57-69.

Furnham, A. (2009) Psychiatric and psychotherapeutic literacy: attitudes to, and knowledge of psychotherapy **International Journal of Social Psychiatry**, 55(6), pp.525-537.

Furnham, A. and Igboaka, A. (2007) Young people's recognition and understanding of schizophrenia: a cross-cultural study of young people from Britain and Nigeria. **International Journal of Social Psychiatry**, 53, pp.430-446.

Gandi, J. C. and Wai, P. S. (2010) Impact of partnership in coping in mental health recovery: An experimental study at the Federal Neuro-Psychiatric Hospital, Kaduna. **International Journal of Mental Health Nursing**, 19(5), pp.322-330.

Garcia, J., et al. (2006) Family support predicts psychiatric medication usage among Mexican American individuals with schizophrenia. **Social Psychiatry and Psychiatric Epidemiology**, 41(7), pp.624-31.

Gater, A., et al. (2015) Assessing the impact of caring for a person with schizophrenia: development of the schizophrenia caregiver questionnaire. **Patient**, 1, pp.1-14.

Gavanas, A. (2004) **Fatherhood politics in the United States: masculinity, sexuality, race, and marriage**. Urbana, University of Illinois Press.

Gerson, K. (2010) **The unfinished revolution: how a new generation is reshaping family, work, and gender in America**. Cambridge, Oxford university press.

Gibbs, G. (2002) **Qualitative data analysis: Explorations with NVivo**. Buckingham, Open University Press.

Girma, E. and Tesfaye, M. (2011) Patterns of treatment seeking behaviour for mental illnesses in southwest Ethiopia: a hospital based study. **British Medical Council Psychiatry**, 11, p.138.

Glick, I., Stekoll, A. and Hays, S. (2011) The role of the family and improvement in treatment maintenance, adherence, and outcome for schizophrenia. **Journal of Clinical Psychopharmacology**, 31(1), pp.82-85.

Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity*. New Jersey Prentice Hall.

Goffman, E. (1961) *Asylums: essays on the social situation of mental patients and other inmates*. New York: Doubleday.

Goh, C. and Agius, M. (2010) The stress-vulnerability model: How does stress impact on mental illness at the level of the brain and what are the consequences?. **Psychiatra Danubina** 22(2), pp.198-202.

Goldberg, H. (1976) **The hazards of being a male: surviving the myth of masculine privilege**. New York, Nash.

Graham, L. and Mphahful, M. (2015) "Let'sGo 50/50": the everyday embodiment of sexuality amongst African young people In: Wyn, J. and Cahill, H. (Eds.): **Handbook of children and youth studies** pp.201-215

Grbich, C. (2007) **Qualitative data analysis**. Thousand Oaks, Sage.

Green, J. and Thorogood, N. (2013) **Qualitative Methods for Health Research**. Thousand Oaks, Sage.

Greenberg, D. and Witztum, E. (1991) Problems in the treatment of religious patients. **American Journal of Psychotherapy**, 4, pp.554-565.

Griffith, D., et al. (2015) The interdependence of African American men's definitions of manhood and health. **Family and Community Health**, 38(4), pp.284-296.

Gubrium, J. F. and Holstein, J. A. (2002) From the individual interview to the interview society. In: Gubrium, J. F. and Holstein, J. A. (Eds.): **Handbook of interview research: context and method**. Thousand Oaks, CA, Sage, pp.3-32

Guest, G., Bunce, A. and Johnson, L. (2006) How many interviews are enough? An experiment with data saturation and variability. **Field Methods**, 18(1), pp.59-82.

Gureje, O. (2002) Psychological disorders and symptoms in primary care: association with disability and service use after 12 months. **Social Psychiatry and Psychiatric Epidemiology**, 37, pp.220-224.

Gureje, O. and Adewunmi, A. (1988) Life events and schizophrenia in Nigerians: a controlled investigation. **The British Journal of Psychiatry**, 153(3), pp.367-375.



Gureje, O., et al. (2007) Cost-effectiveness of an essential mental health intervention package in Nigeria. **World Psychiatry**, 6(1), pp.42-48.

Gureje, O. and Lasebikan, V. (2006) Use of mental health services in a developing country: Results from the survey of Nigerian Mental Health and Well-Being. **Social Psychiatry and Psychiatric Epidemiology**, 41, pp.44-49.

Harper, S., Towers-Evans, H. and MacCabe, J. (2015) The aetiology of schizophrenia: what have the Swedish Medical Registers taught us?. **Social Psychiatry and Psychiatric Epidemiology**, 50(10), pp.1471-1479.

Haro, J. M., et al. (2014) Symptomatic remission and patient quality of life in an observational study of schizophrenia: Is there a relationship? **Psychiatry Research**, 220(1), pp.163-169.

Harris, C. (2012a) Gender-age systems and social change : a Haugaardian power analysis based on research from northern Uganda. **Journal of Political Power**, 5(3), pp.475-492.

Harris, C. (2012b) Masculinities and religion in Kaduna, Nigeria: a struggle for continuity at a time of change. **Religion and Gender**, 2(2), pp.207-230.

Harrison, G., et al. (2001) Recovery from psychotic illness: A 15 and 25-year international follow up study. **British Journal of Psychiatry**, 178, pp.506-517.

Harrison, J. (1978) Warning: the male sex role may be dangerous to your health. **Journal of Social Issues**, 34(1), pp.65-68.

Hauari, H. and Hollingworth, K. (2009). **Understanding fathering masculinity, diversity and change**. London, Joseph Rowntree.

Heaton, M. M. (2013) **Black skin, white coats: Nigerian psychiatrists, decolonization, and the globalization of psychiatry**. USA: Ohio University Press.

Hennink, M. et al. (2016) Code Saturation Versus Meaning Saturation: How Many Interviews Are Enough?, **Qualitative Health Research** 27(4), pp. 591-608.

Hendricks, L., Swartz, S. and Bhana, A. (2010) Why young men in South Africa Plan to become teenage fathers: implications for the development of masculinities within contexts of poverty. **Journal of psychology in Africa**, 20(4), pp.527-536.

Heres, S., Lambert, M. and Vauth, R. (2014) Treatment of early episode in patients with schizophrenia: the role of long acting antipsychotics. **European Psychiatry**, 29, pp.1409-1413.

Hewson, M. (2015) Integrating Indigenous Knowledge with Science Teaching. In: Hewson, M. (Ed.): ***Embracing Indigenous Knowledge in Science and Medical Teaching***. Springer pp.119-131

Hills, D., et al. (2013) Traditional healers research project. London, The Tavistock Institute.

Hobson, B. ed. (2002) **Making men into fathers: men, masculinities, and the social politics of fatherhood**. Cambridge, Cambridge University Press.

Honings, S., et al. (2015) Psychotic experiences and risk of self-injurious behaviour in the general population: a systematic review and meta-analysis. ***Psychological Medicine***, 46(2), pp.237-251.

Holloway, I. and Wheeler, S. (2013) ***Qualitative Research in Nursing and Healthcare***. London, John Wiley and Sons.

Hunter, M. (2005) Cultural politics and masculinity: multiple partners in historical perspective in KwaZulu Natal. ***Culture, Health and Sexuality***, 7(4), pp.389-403.

Ibrahim, A. et al. (2016) Pathways to psychiatric care for mental disorders: a retrospective study of patients seeking mental health services at a public psychiatric facility in Ghana. ***International Journal of Mental Health Systems***, 10(1), pp. 1-11.

Ibrahim, A. W., et al. (2015) Medication-related factors of non adherence among patients with schizophrenia and bipolar disorder: Outcome of a cross-sectional survey in Maiduguri, North-eastern Nigeria. ***Journal of Neuroscience and Behavioural Health***, 7(5), pp.31-39.

Igberase, O., et al. (2010) Burden of care among relatives of patients with schizophrenia in mid-western Nigeria. ***International Journal of Social Psychiatry***, 58(2), pp.131–137.

Ikwuka, U. et al. (2016) Pathways to mental healthcare in south-eastern Nigeria, ***Transcultural Psychiatry***, 53(5), pp. 574-594.

Ikwuka, U. et al. (2014) Causal attribution of mental illness in south-eastern Nigeria. ***International Journal Social Psychiatry*** 60, pp.274-279.

Iroegbu, E. (2007) **Marrying wealth, marrying poverty: gender and bridewealth power in an African society-the case of Igbo**. Victoria, Trafford.

Iroegbu, P. (2005) Healing insanity: skills and expert knowledge of Igbo healers. ***African Development***, 3, pp.78-92.

Ishola, A. G. (2013) Burden of families caring for people living with schizophrenia in two selected hospitals in Ibadan, Nigeria. ***West African Journal of Nursing***, 24(1), pp.1-15.

Issa, B. A., et al. (2008) Caregivers' knowledge of etiology of mental illness in a tertiary health institution in Nigeria. ***Iranian Journal of Psychiatry and Behavioral Sciences***, 2(1), pp.43-49.

Izugbara, C., Kabiru, C. and Ezeh, A. (2011) Running against the wind: studying reproductive norms and behaviour in Islamic northern Nigeria. In: Barrett, B. and Groes-Green, C. (Eds.): **Studying intimate matters: engaging methodological challenges in studies on gender, sexuality and reproductive health in Africa**. Kampala, Fountain, pp.1-15

Jack-Ide, I. O., Makoro, B. P. and Azibiri, B. (2013) Pathways to mental health care services in the Niger delta region of Nigeria. **Journal Research Nursing and Midwifery**, 2, pp.22-29.

Jack-Ide, I. O., Uys, L. R. and Middleton, L. E. (2013) *Mental health care policy environment in Rivers State: experiences of mental health nurses providing mental health care services in neuro-psychiatric hospital, Port Harcourt, Nigeria*. **International Journal of Mental Health Systems**, 7, pp.8-14.

Jackson, L. (1992) The place of psychiatry in colonial and early postcolonial Zimbabwe', **International Journal of Mental Health** 28(2), pp. 38-71.

James, B. O. et al. (2014) Clergy as collaborators in the delivery of mental health care: An exploratory survey from Benin City, Nigeria. **Transcultural Psychiatry**, 51(4), pp. 569-580.

James, O. (2014) Not in your Genes: time to accept the null hypothesis of the human genome project. **Attachment**, 8(3), pp.281-296.

Jamison, D., et al. eds. (2006) **Disease and mortality in sub-saharan Africa**. Washington, The International Bank for Reconstruction and Development/World Bank.

Jegede, A. (2005) The notion of "Were" in Yoruba conception of mental illness. **Nordic Journal of African Studies** 14(1), pp.117-126.

Jewkes, R. and Morrell, R. (2010) Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. **Journal of the International AIDS society**, 13(1), pp.1-11.

Jones, J., et al. (2010) Psychiatric wards: places of safety? **Journal of Psychiatric and Mental Health Nursing**, 17(2), pp.124-130.

Kalathil, J., et al. (2011). **Recovery and resilience: African, African-Caribbean and South Asian women's narratives of recovering from mental distress**. London, *Mental Health Foundation*

Kaliski, S. (1992) 'Psychiatry in the "New South Africa"', **The Psychiatrist** 16(6), pp. 343-345.

Kaminsky, A., Roberts, L. and Brody, J. (2003) Influences upon willingness to participate in schizophrenia research: an analysis of narrative data from 63 people with schizophrenia. **Ethics and Behavior**, 13(3), pp.279-302.

Kanu, I. A. (2014) African traditional religion in a globalizing World. **International Journal of Humanities Social Sciences and Education**, 1(8), pp.4-12.

Kanu, I. A. and Paul, T. H. (2011) Ethical and religious values in African traditional religion with Christian analogies. **International Journal of Theology and Reformed Tradition**, 3, pp.199-212.

Keating, F. (2009) African and Caribbean men and mental health. **Ethnicity and Inequalities in Health and Social Care**, 2(2), pp.41-53.

Kebede, D., et al. (2003) Onset and clinical course of schizophrenia in Butajira-Ethiopia **Social Psychiatry and Psychiatric Epidemiology**, 38(11), pp.625-631.

Kendler, K. (2015) A joint history of the nature of genetic variation and the nature of schizophrenia. **Molecular Psychiatry**, 20(1), pp.77-83.

Kerstetter, K. (2012) Insider, outsider or somewhere in between: the impact of researchers identities on the community-based research process. **Journal of Rural Social Sciences**, 27(2), pp. 99-115.

Khalifa, N., et al. (2011) Beliefs about jinn, black magic and the evil eye among Muslims: age, gender and first language influences. **International Journal of Culture and Mental Health**, 4, pp.68-77.

Khapoya, V. (2015) **The African Experience**. New York, Routledge.

Khoury, N. M. et al. (2012) Explanatory models and mental health treatment: is vodou an obstacle to psychiatric treatment in rural Haiti?. **Culture, Medicine, and Psychiatry**, 36(3), pp. 514-534.

Kimmel, M. and Messner, M. (1995) *Men's lives*. Boston: Allyn and Bacon.

King, B. (2012) "We pray at the church in the day and visit the sangomas at night": health discourses and traditional medicine in rural South Africa. **Annals of the Association of American Geographers**, 102(5), pp.1173-1181.

Kinsella, K. B., Anderson, R. A. and Andersen, W. T. (1996) Coping skills strengths and needs as perceived by adults offspring and siblings of people with mental illness: a retrospective study. **Psychiatric Rehabilitation Journal**, 20(2), pp.24-32.

Kirkbride, J. B. et al. (2012) 'Incidence of schizophrenia and other psychoses in England, 1950–2009: systematic review and meta-analyses', **PloS one**, 7(3), pp. 1-21.

Knapp, M., Mangalore, R. and Simon, J. (2004) The global costs of schizophrenia. **Schizophrenia Bulletin**, 30, pp.279-293.

Kraepelin, E. (1919) **Dementia praecox and paraphrenia**. New York, Krieger.

Krause, K. (2014) Space in pentecostal healing practices among Ghanaian migrants in London. **Medical Anthropology**, 33(1), pp.37-51.

Kurylo, A. (2016) *Negotiating Group Identity in the Research Process: Are You In or Are You Out?* . USA: Rowman & Littlefield.

Kvale, S. (2007) **Doing Interviews**. London, Sage.

Kymalainen, J. A. and Weisman, A. G. (2008) Expressed emotion, communication deviance, and culture in families of patients with schizophrenia: a review of the literature. **Cultural Diversity and Ethnic Minority Psychology**, 14(2), pp.85-91.

Lacro, J. P., et al. (2002) Prevalence of and risk for medication adherence in patients with schizophrenia: a comprehensive review of recent literature. **Journal Clinical Psychiatry**, 63, pp.892-909.

Laher, S. (2014) An overview of illness conceptualizations in African, Hindu, and Islamic traditions: towards cultural competence. **South African Journal of Psychology**, 44(2), pp.191-204.

Laing, R. D. (1960) **The Divided Self**. London, Tavistock.

Lally, J. and MacCabe, J. (2015) Antipsychotic medication in schizophrenia: a review. **British Medical Bulletin**, 0, pp.1-11.

Lasebikan, V. O. and Ayinde, O. O. (2013) Family burden in caregivers of schizophrenia patients: prevalence and socio-demographic correlates. **Indian Journal of Psychological Medicine**, 35(1), pp.60-66.

Lasebikan, V. O., Owoaje, E. T. and Asuzu, M. C. (2012) Social network as a determinant of pathway to mental health service utilization among psychotic patients in a Nigerian hospital. **Annals of Africa Medicine**, 11, pp.12-20.

Law, H. and Morrison, A. (2014) Recovery in psychosis: a delphi study with experts by experience. **Schizophrenia Bulletin** 40(6), pp.1347-1355.

Lawal, M., et al. (2014) Prevalence, pattern and factors associated with psychiatric disorders among persons arrested for violent crimes in Ife/Modakeke Area southwestern Nigeria. **Journal of behavioural and brain Science**, 4, pp.535-543.

Leamy, M., et al. (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. **British Journal of Psychiatry**, 199(6), pp.445-452.

Leavey, G. et al. (2012) Finding common ground: the boundaries and interconnections between faith-based organisations and mental health services. **Mental Health, Religion and Culture**, 15(4), pp. 349-362.

Lieberman, R. (2012) Phase-specific recovery from schizophrenia. **Psychiatric Annals** 42(6), pp.211-17.

Lifongo, L. L., et al. (2014) A bioactivity versus ethnobotanical survey of medicinal plants from Nigeria, West Africa. **Natural Products and Bioprospecting**, 4(1), pp.1-19.

Lim, A., Hoek, H. W. and Blom, J. D. (2014) The attribution of psychotic symptoms to jinn in Islamic patients. **Transcultural Psychiatry**, 0(0), pp.1-15.

Lincoln, Y. and Guba, E. (1985) **Naturalistic Inquiry**. Newbury, CA, Sage.

Lindsay, L. (2007) **Working with gender: the emergence of the male breadwinner in colonial south-western Nigeria**. Africa after gender. Bloomington, Indiana University Press.

Loewenthal, K. and Alan, C. (2011) Mental health, religion and culture. **Psychologist**, 24(4), pp.256-260.

Lund, C., et al. (2012) PRIME: a programme to reduce the treatment gap for mental disorders in five low-and middle-income countries. **PLoS Med**, 9(12).

Lui, L. (2013) **Re-negotiating gender: household division of labour when she earns more than he does**. New York, Springer.

MacKinnon, R., Michels, R. and Buckley, P. (2009) **The Psychiatric Interview in Clinical Practice**. Arlington, American Psychiatric Publishing.

Magliano, L., et al. (2013) Differences in views of schizophrenia during medical education: a comparative study of 1st versus 5th–6th year Italian medical students. **Social Psychiatry and Psychiatric Epidemiology**, pp.1647-1655.

Masciadrelli, B., Pleck, J. and Stueve, J. (2006) Father's role model perceptions themes and linkages with involvement. **Men and Masculinities**, 9(1), pp.23-34.

Mason, M. (2010) Sample size and saturation in PhD studies using qualitative interviews. **Qualitative Social Research**, 11(3), pp.1-15.

Mason, J. (2002) **Qualitative Researching**. 2nd ed. London, Sage.

Malterud, K. et al (2016) 'Sample size in qualitative interview studies: guided by information power', **Qualitative Health Research**, 26(13), pp. 1753-1760.

Mays, N. and Pope, C. (2006) Quality in qualitative health research. In: Mays, N. and Catherine., P. (Eds.): **Qualitative Research in Health Care**. Oxford, Blackwell Publishing, pp.82-101

Meshach, E., King, K. and Fulton, J. (2014) 'Poor adherence to antipsychotics amongst schizophrenia patients in Nigeria', *International Journal of Culture and Mental Health*, 7(3), pp. 246-258.

Messner, M. (1993) Changing men and feminist politics in the United States. **Theory and Society** 22(5), pp.723-737.

Miescher, S. (2005) **Making men in Ghana**. Indiana, University Press.

Miller, J. and Glassner, B. (2011) The "inside" and the "outside": finding realities in interviews. In: Silverman, D. (Ed.): **Qualitative Research**. London, Sage, pp.131-148

Mohr, S., et al. (2012) Spirituality and religion in outpatients with schizophrenia: a multi-site comparative study of Switzerland Canada and United States. **International Journal Psychiatry in Medicine**, 44(1), pp.29-52.

Morgan, C. (2007) The role of social care. **Psychiatry** 6(8), pp.347-349.

Moller, H., et al. (2015) DSM-5 reviewed from different angles. **European Archives of Psychiatry and Clinical Neuroscience**, 265 pp.87-106.

Moller-Leimkuhler, A. M. and Wiesheu, A. (2012) Caregiver burden in chronic mental illness: the role of patient and caregiver characteristics. **European Archives of Psychiatry and Clinical**, 262(2), pp.157-166.

Morrell, R. (2001) **Changing masculinities in South Africa**. Pietermaritzburg, University of Natal.

Morrell, R., Jewkes, R. and Lindegger, G. (2012) Hegemonic masculinity/masculinities in South Africa: culture, power, and gender politics. **Men and Masculinities**, 15(1), pp.11-30.

Morrell, R. and Ouzgane, L. (2005) **African masculinities: men in Africa from the late 19th century to present**. New York, Palgrave.

Morrison, J. (2014) **DSM-5 made easy: the clinician's guide to diagnosis**. New York, Guilford Press.

Mosanya, J. T., et al. (2014) Self-stigma, quality of life: an outpatient clinic survey in Nigeria. **International Journal of Social Psychiatry**, 60(4), pp.377-386.

Mpofu, E., Peltzer, K. and Bojuwoye, O. (2011) Indigenous healing practices in sub-Saharan Africa. In: Mpofu, E. (Ed.): **Counseling people of African ancestry**. New York, Cambridge University Press., pp.3-21

Mudiare, P. (2013) The perception of gender roles and its implication for spousal violence in Kaduna Metropolis, Nigeria. **European Scientific Journal**, 9(23), pp.239-258.

Mueser, K. T., et al. (2013) Psychosocial treatments for schizophrenia. **Annual Review of Clinical Psychology**, 9(465-497).

Muir-Cochrane, E. and Gerace, A. (2015) People hospitalised on acute psychiatric wards report mixed feelings of safety and vulnerability. **Evidence Based Nursing** 18(1), pp.31-40.

Napo, F., Heinz, A. and Auckenthaler, A. (2012) Explanatory models and concepts of West African Malian patients with psychotic symptoms. **European Psychiatry** 27, pp.544-49.

National Institute for Clinical Excellence (2014). **Psychosis and schizophrenia in adults: treatment and management**. London, Royal college of psychiatrists.

National Population Census (2006). **Legal notice on publication of the details of the breakdown of the National and State Provisional Totals 2006 Census** Nigeria, Federal Government of Nigeria.

National Population Commission (2014). **Demographic and Health Survey 2013**. Abuja, Nigeria, Federal Government of Nigeria.

Neeleman, J. and Lewis, G. (1994) Religious identity and comfort beliefs in three groups of psychiatric patients and a group of medical controls. **International Journal Social Psychiatry**, 40, pp.124-34.

Ngui, A., Vasiliadis, H. and Tempier, R. (2013) Factors associated with adherence over time to antipsychotic drug treatment. **Clinical Epidemiology and Global Health**, 13(3), pp.1-7.

Nicoleau, A., et al. (2014) Doing what it takes to make it wor flexibility, relational focus, and stability among long-term couples with children. **Journal of Family Issues**, 1, pp.1-19.

Nirmala, B. P., Vranda, M. N. and Reddy, S. (2011) Expressed emotion and caregiver burden in patients with schizophrenia. **Indian Journal of Psychological Medicine**, 55(2), pp.119-122.

Nunn, N. (2011) **Christians in colonial Africa**. Massachusetts, Harvard University.

Nunn, N. (2014) Gender and missionary influence in colonial Africa. In: Akyeampong, E., Bates, R., Nunn, N. et al. (Eds.): **Africa's development in historical perspective**. New York, Cambridge University Press, pp.489-512

Nwagbara, E. (2011) The story of structural adjustment programme in Nigeria from the perspective of the organised labour. **Australian Journal of Business and Management Research**, 1(7), pp.30-41.

Nwosu, I. E. (2012) Gender role perceptions and the changing role of women in Nigeria. **International Journal of Agriculture and Rural Development**, 15(3), pp.1240-1246.



Nwoye, M. (2013) Gender responsive entrepreneurial economy of Nigeria: enabling women in a disabling environment. **Journal of International Women's Studies**, 9(1), pp.167-175.

Nye, A. (2005) Locating masculinity: some recent work on men. **Journal of Women in Culture and Society**, 30(3), pp.1937-1962.

O'Neil, J. (1982) Gender role conflict and strain in men's lives: implications for psychiatrists, psychologists, and other human service providers. In: Solomon, K. L., N. (Ed.): **Men in transition: changing male roles theory and therapy**. New York, Plenum, pp.5-44

O'Neil, J. (2008) Summarizing 25 years of research on men's gender role conflict using the gender role conflict scale: new research paradigms and clinical implications. **The Counseling Psychologist**, 38, pp.358-445.

Oakley, A. (2015) **Sex, gender and society**. Surrey, Ashgate.

Odimegwu, C. and Adedini, S. (2013) Masculinity and health in Nigeria: vulnerabilities, indifference and options. **Gender and Behaviour**, 11(2), pp.5707-5719.

Odimegwu, C. and Okemgbo, C. (2008) Men's perception of masculinities and sexual health risks in Igboland Nigeria. **International Journal of Men's Health**, 7(1), pp.21-39.

Odinka, P., et al. (2015) The sociocultural conceptualisations of schizophrenia and patterns of help-seeking in south-east Nigeria. **Mental Health, Religion and Culture**, 18(2), pp.85-96.

Office for National Statistics (2012) **2011 census: key statistics for local authorities in England and Wales**. London, Office for National Statistics.

Office of Public Sector Information (2000) Transport Act 2000. London, Her Majesty Stationery Office.

Ogbeide, V. (2011) Of wine carrying and bridal train: A portrayal of traditional Igbo marriage. **Journal of Sociology and Social Anthropology**, 2(2), pp.103-110.

Ogbonna, C. (2012) Structural adjustment program (SAP) in Nigeria: an empirical assessment. **Journal of Banking**, 6(1), pp.19-40.

Ohaeri, J. O. (1998) Perception of the social support role of the extended family network by some Nigerians with schizophrenia and affective disorder. **Social Science Medicine**, 47(10), pp.1463-1472.

Ohaeri, J. U. (2001) Caregiver burden and psychotic patients' perception of social support in a Nigerian setting. **Social Psychiatry and Psychiatric Epidemiology**, 36(2) Apr 24, pp.86-93.

Okonkwo, A. (2009). **The evolution of gender relations in Igbo nation and the discourse of cultural imperialism**. Sweden University of Malmo, Department of International Migration and Ethnic Relations.

Olabode, T., et al. (2014) Millennium Development Goals (MDGS) in Nigeria: Issues and Problems. **Global Journal of Human-Social Science Research**, 14(5), pp.1-12

Olawoye, J., et al. (2004) Social construction of manhood in Nigeria: implications for male responsibility in reproductive health. **African Population Studies**, 19(2), pp.1-20.

Oliffe, J. and Mroz, L. (2005) Men interviewing men about health and illness: ten lessons learned. **The Journal of Men's Health and Gender**, 2(2), pp.257-260.

Oliffe, J. L., et al. (2010) Connecting masculinity and depression among international male university students. **Qualitative Health Research**, 20(7), pp.987-998.

Olusina, A. K., Ohaeri, J. U. and Olatawura, M. O. (2002) Patient and staff satisfaction with the quality of in-patient psychiatric care in a Nigerian general hospital. **Social Psychiatry and Psychiatric Epidemiology**, 37(6), pp.283-8.

Oluwatomipe, A. P., et al. (2015) 'Exploring the hindrances to women entrepreneurship, development and prosperity in Nigeria', **Journal of Entrepreneurship**, 3(13), pp. 1-11.

Oluwagbemi-Jacob, D. and Chima, E. U. (2015) Gender equality, gender inequality, and gender complementarity: insights from Igbo traditional culture. **Philosophy** 5(5), pp.223-232.

Omadjohwoefe, O. S. (2011) Gender role differentiation and social mobility of women in Nigeria. **Journal of Social Science**, 27(1), pp.67-74.

Omoaregba, J., James, B. and Eze, G. (2009) Schizophrenia spectrum disorders in a Nigerian family: 4 case reports. **Cases Journal** 2(14), pp.1-4.

Omobola, O. C. (2013) An overview of taboos and superstition among Yoruba of south-west Nigeria. **Mediterranean Journal of Social Sciences**, 4(2), pp.221-226.

Omoleke, I. I. (2013) The relevance of the African traditional medicine (alternative medicine) to health care delivery system in Nigeria. **Journal of Developing Areas**, 47(1), pp.319-338.

Omotoye, R. (2016) **"The use of African Traditional medicine, Western medicine and Christian faith healing in Yorubaland, Southwest Nigeria"**, in Aderibigbe, I.O., Omotoye, R, and Akande, Lydia. (ed.) *Contextualising Africans and globalisation: expressions in sociopolitical and religious contents and discontents*. USA: Rowman and Littlefield.

Onken, S. J., et al. (2007) An analysis of the definition and elements of recovery: A review of the literature. **Psychiatric Rehabilitation Journal**, 31, pp.9-22.

Onyima, B. N. (2015) Marriage ceremony: the clash between Traditional marriage rites and Western Marriage. **Journal of Religion and Human Relations**, 1(6), pp.171-180.

Opdenakker, R. (2006) Advantages and disadvantages of four interview techniques in qualitative research. **Qualitative Social Research**, 7(4), pp.1-13.

Opler, L., et al. (2013) Pharmacotherapy of cognitive deficits in schizophrenia. **CNS Spectrums**, 19(2), pp.142-156.

Osahon, P. T. et al. (2016) 'Prescription pattern and cost analysis of antipsychotics in a tertiary hospital in south-South Nigeria', **Journal of Pharmaceutical and Allied Sciences**, 13(1), pp. 2344-2353.

Owoye, O. and Onafowora, O. (2009) The choice of monetary targets in periods of structural adjustment: the case of Nigeria. **Journal of African policy studies**, 14(2), pp.1-30.

Oyekanmi, F. D. (2015) Institutionalization of gender inequality in Nigeria: implications for the advancement of women. **Population Review**, 44(1), pp.56-71.

Oyekanmi, A. K., et al. (2012) Demographic and clinical correlates of sexual dysfunction among Nigerian male outpatients on conventional antipsychotic medications. **BMC Research Notes**, 5(1), pp.267-274.

Oyelakin, R. T. (2009) Yoruba traditional medicine and the challenge of integration. **Journal of Pan African Studies**, 3(3), pp.73-90.

Oyewumi, O. ed. (2005) **African gender studies**. Basingstoke, Palgrave Macmillan.

O'Brien, R., Hunt, K. and Hart, G. (2005) "It's caveman stuff, but that is to a certain extent how guys still operate": men's accounts of masculinity and help seeking. **Social Science and Medicine**, 61, pp.503-16.

Putton, M. (2015) **Qualitative research and evaluation method: integrating theory and practice**. Thousand Oaks, Sage.

Pargament, K. (2001) **The psychology of religion and coping: theory, research, practice**. New York, Guilford.

Parkin, D. (2007) In touch without touching: Islam and healing. In: Littlewood, R. (Ed.): **The importance of knowing about not knowing**. Walnut Creek, CA, Left Coast Press, pp.127–139

Parshotam, R. K. and Joubert, P. M. (2015) Views of schizophrenia patients on the effects of cannabis on their mental health. **South African Journal of Psychiatry**, 21(2), pp.57-61.

Pernice-Duca, F. (2010) Family network support and mental health recovery. **Journal of Marital and Family Therapy**, 36(1), pp.13-27.

Petersen, I., Lund, C. and Stein, D. (2011) Optimizing mental health services in low-income-and middle-income countries. **Current Opinion in Psychiatry**, 24(4), pp.318-323.

Petithomme, M. (2013) Much ado about nothing? The limited effects of structural adjustment programmes and the highly indebted poor countries initiative on the reduction of external debts in sub-Saharan Africa: An empirical analysis. **African Journal of Political Science and International Relations**, 7(2), pp.107-120.

Pitt, L., et al. (2007) Researching recovery from psychosis- a user-led project. **The Psychiatrist**, 35(2), pp.55-60.

Pleck, J. H. (1981) **The Myth of Masculinity**. London, MIT Press.

Pleck, J. H. (1995) The gender role strain paradigm: an update. In: Levant, R. F. and Pollack, W. S. (Eds.): **A new psychology of men**. New York, Basic Books, pp.11-32

Promundo & Care Rwanda (2012). **Journeys of transformation: Engaging men in Rwanda as allies in women's economic empowerment and partners in caregiving**. Washington DC, USA, and Kigali, Rwanda, Promundo and CARE.

Punch, K. (2005) **Introduction to social research: quantitative and qualitative approaches**. Thousand Oaks, Sage.

Quek, K. (2013) The evolving challenges of modern-day parenthood in Singapore. In: Selin, H. (Ed.): **Parenting across cultures: childbearing, motherhood and fatherhood in non-western cultures**. New York, Springer, pp.145-161

Ram, S., et al. (2014) A village possessed by witches: a mixed-methods case-control study of possession and mental disorders in rural Nepal. **Culture, medicine, and psychiatry**, 38(4), pp.642-668.

Ramsay, C. E., Stewart, T. and Compton, M. T. (2012) Unemployment among patients with newly diagnosed first-episode psychosis: prevalence and clinical correlates in a US sample. **Social Psychiatry and Psychiatric Epidemiology**, 47(5), pp.707-803.

Ratele, K. (2008) Analysing males in Africa: certain useful elements in considering ruling masculinities. **Journal of Asian and African Studies**, 7(4), pp.515-536.

Ratele, K. (2011) Male sexualities and masculinities. In: Temale, S. (Ed.): **African sexualities**. Cape Town, Pambazuka, pp.399-420

Ratele, K., et al. (2010) "We do not cook, we only assist them": constructions of hegemonic masculinity through gendered activity. **Journal of Psychology in Africa** 20(4), pp.557-567.

Read, J. (2003) The sources of gender role attitudes among christian and muslim Arab-American women. **Sociology of Religion**, 64(2), pp.207-222.

Read, J., et al. (2006) Prejudice and schizophrenia: a review of the "mental illness like any other" approach. **Acta psychiatrica Scandinavica**, 1(16).

Read, U. (2012) "I want the one that will heal me completely so it won't come back again": the limits of antipsychotic medication in rural Ghana. **Transcultural Psychiatry**, 49(3), pp.438-460.

Read, U., Adiibokah, E. and Nyame, S. (2009) Local suffering and the global discourse of mental health and human rights: an ethnographic study of responses to mental illness in rural Ghana. **Globalization and Health**, 5(13), pp.1-13.

Read, U., Doku, V. and Aikins, A. (2015) Schizophrenia and psychosis in West Africa. In: Akyeampong, E., Hill, A. G. and Kleinman, A. (Eds.): **The culture of mental illness and psychiatric practice in Africa**. Indianapolis, Indiana University Press, pp.73-111

Regier, D., et al. (2013) DSM-5 field trials in the United States and Canada: test-retest reliability of selected categorical diagnoses. **American Journal of Psychiatry**, 170(1), pp.59-70.

Ricardo, C., et al. (2010) **Program H and Program M: Engaging young men and empowering young women to promote gender equality and health**. Washington DC, Pan American Health Organisation (PAHO) and Promundo.

Ridgway, P. (2001) Restorying psychiatric disability: learning from first person recovery narratives. **Psychiatric Rehabilitation Journal**, 24(4), pp.335-343.

Risman, B. and Davis, G. (2013) From sex roles to gender structure. **Current Sociology**, 5(6), pp.733-755.

Ritchie, J. et al. (2013) *Qualitative research practice: A guide for social science students and researchers*. USA Sage.

Roberts, J. (2009) African-American belief narratives and the African cultural tradition. **Research in African Literatures**, 40(1), pp.112-126.

Robertson, S. (2007) **Understanding men and health: masculinities, identity and well-being**. Buckingham, Open University Press.

Robertson, S. (2006) Masculinity and reflexivity in health research with men, **Auto/Biography**, 14(4) pp.302-319

Robinson, O. (2014) Sampling in Interview-Based Qualitative Research: a theoretical and Practical Guide, **Qualitative Research in Psychology**, 11(1), pp. 25-41

Robinson, M., Keating, F. and Robertson, S. (2011) Ethnicity, gender and mental health. **Diversity in Health and Care**, 8(2), pp.81-92.

Rosenhan, D. L. (1973) 'On being sane in insane places', **Science**, 179(4070), pp. 250-258.

Rubin, H. and Rubin, I. (2012) **Qualitative interviewing: the art of healing**. 3rd ed. London, Sage.

Sandelowski, M. (1995) Sample size in qualitative research. **Research in Nursing & Health**, 18(2), pp.179-183.

Sadowsky, J. (1999) **Imperial bedlam: institutions of madness in colonial southwest Nigeria**. Berkeley: University of California Press.

Saldana, J. (2013) **The coding manual for qualitative researchers**. 2nd ed. Thousand Oaks, Sage.

Sales, C. S. and Schlaff, A. L. (2010) Reforming medical education: a review and synthesis of five critiques of medical practice. **Sale Social Science and Medicine**, 70(11), pp.1665-1668.

Sanuade, O. and Boatemaa, S. (2015) Caregiver profiles and determinants of caregiving burden in Ghana. **Public Health**, 129, pp.941-947.

Sardien, A. (2010) "Spots of a leopard: on being a man." **Journal of Psychology**, 20(4), pp.647-648.

Selin, H. ed. (2013) **Parenting across cultures: childbearing, motherhood and fatherhood in non-western cultures**. New York, Springer.

Selten, J. P. and Cantor-Graae, E. (2005) Social defeat: risk factor for schizophrenia? **British Journal of Psychiatry**, 187, pp.101-102.

Selten, J. P., Cantor-Graae, E. and Kahn, R. S. (2007) Migration and schizophrenia. **Current Opinion Psychiatry**, 20(2), pp.111-115.

Silberschmidt, M. (1999) **Women forget that men are the masters: gender antagonism and socio-economic change in Kisii district, Kenya**. Sweden, Nordiska Afrikainstitutet.

Silberschmidt, M. (2005) Poverty, male disempowerment, and male sexuality: rethinking men and masculinities in rural and urban East Africa. In: Ouzgane, L. and Morrell, R. (Eds.): **African masculinities: men in Africa from the late nineteenth century to the present**. Palgrave, Macmillan, pp.189-203

Silberschmidt, M. (2011) Intimate matters as a taboo and a burning issue: experiences from qualitative data collection in urban Uganda and Tanzania. In: Barrett, B. and Groes-Green, C. (Eds.): **Studying intimate matters: engaging methodological challenges in studies on gender, sexuality and reproductive health in Africa**. Kampala, Fountain, pp.120-145

Silverman, D. (2015) **Interpreting qualitative data**. 5 ed. London, Sage.

Slade, M. (2013) **100 ways to support recovery: a guide for mental health professionals**. London, Rethink.

Snow, R., Winter, R. and Harlow, S. (2013) Gender attitudes and fertility aspirations among young men in five high fertility East African countries. **Studies in Family Planning**, 44(1), pp.1-24.

Somoye, E., Babalola, E. and Adebawale, T. (2015) Prevalence and risk factors for anxiety and depression among commercial bank workers in Abeokuta, south- western Nigeria. **Journal of Behavioural Health**, 4(2), pp.55-62.

Spaniol, L., et al. (2002) The process of recovery from schizophrenia. **International Review of Psychiatry**, 14, pp.327-336.

Stansfeld, S., et al. (2014) Stressors and common mental disorder in informal carers: an analysis of the English adult psychiatric morbidity survey 2007. **Social Science and Medicine**, 120, pp.190-198.

Stenhouse, R. (2013) "Safe enough in here?" patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward. **Journal of Clinical Nursing** 22, 22(21), pp.3109-3119.

Sternberg, P., White, A. and Hubley, J. (2007) Damned if they do, damned if they don't: tensions in Nicaraguan masculinities as barriers to sexual and reproductive health promotion. **Men and Masculinities**, 10(5), pp.538-556.

Stockdale, A. (2002) Tools for digital audio recording in qualitative research. **Social Research Update**, 38, pp.1-4.

Stuhlmacher, A. and Linnabery, E. (2013) Gender and negotiation: a social role analysis. In: Olekalns, M. and Adair, W. (Eds.): **Handbook of research on negotiation**. Massachusetts, Edward Elgar, pp.221-248

Swami, V., et al. (2008) Beliefs about schizophrenia and its treatment in Kota Kinabalu, Malaysia. **International Journal of Social Psychiatry**, 54, pp.164-179.

Sweetman, C. (2013) Introduction: working with men on gender equality. **Gender and Development** 21(1): 1-13.

Syed, I. (2003) Spiritual medicine in the history of Islamic medicine. ***Journal of the International Society for the study of Islamic medicine***, 46, pp.1-15.

Szasz, T. (1960) 'The Myth of Mental Illness'. ***American Psychologist*** 15(2), pp. 113-118.

Tatira, L. (2014) Shona belief systems: finding relevancy for a new generation. ***Journal of Pan African Studies***, 6(8), pp.106-17.

Thornicroft, G. and Tansella, M. (2013) The balanced care model for global mental health. ***Psychological Medicine***, 43(4), pp.849-863.

Thomas, J. et al. (2015) Conceptualising mental health in the United Arab Emirates: the perspective of traditional healers. ***Mental Health, Religion and Culture***, 18(2), pp. 134-145.

Teferra, S., et al. (2013) Perspectives on reasons for non-adherence to medication in persons with schizophrenia in Ethiopia: a qualitative study of patients, caregivers and health workers. ***BMC Psychiatry***, 13(1), pp.1-11.

Temale, S. (2011) Researching and theorising sexualities in Africa. In: Temale, S. (Ed.): ***African sexualities***. Cape Town, Pambazuka.

Tengland, P. A. (2008) Empowerment: a conceptual discussion. ***Health Care Analysis***, 16(2), pp.77-96.

Tengland A. P. (2010) Health promotion and disease prevention: a real difference for public health practice. ***Health Care Analysis***, 18(3), pp.203-221.

Tengland, P.A. (2012) Behavior change or empowerment: on the ethics of health-promotion strategies. ***Public Health Ethics*** 5(2), pp.140-153.

Tew, et al. (2012) Social factors and recovery from mental health difficulties: a review of the evidence. ***British Journal of Social Work*** 42(3), pp.443-460.

Topor, A., et al. (2011) Not just an individual journey: social aspects of recovery. ***International Journal of Social Psychiatry***, 57(1), pp.90-99.

Topor, A., et al. (2006) Others: the role of family, friends, and professionals in the recovery process. ***American Journal of Psychiatric Rehabilitation***, 9, pp.17-37.

Tracy, S. (2010) Qualitative quality: eight "big-tent" criteria for excellent qualitative research. ***Qualitative Inquiry***, 16(10), pp.837-851.

Tuckett, A. G. (2005) Applying thematic analysis theory to practice: a researcher's experience. ***Contemporary Nurse***, 19, pp.75-87.



Uchendu, E. (2007) Masculinity and Nigerian Youths. **Nordic Journal of African studies**, 16(2), pp.279-297.

Ukpong, D. and Mosaku, S. (2009) Demographic and clinical correlates of length of stay in a Nigerian university hospital psychiatric unit. **Turkish Journal of Psychiatry**, 20(1), pp.49-55.

Utoblo, B. (2010) **Narratives of recovery from psychosis of African Caribbean men**. Leeds Metropolitan University, Faculty of Health and Social Sciences.

United Nations (1995) Beijing Declaration and Platform for Action. New York, United Nations.

United Nations (2015). The Millennium Development Goals Report 2015. New York, United Nations.

Unterhalter, E., Heslop, J. and Mamedu, A. (2013) Girls claiming education rights: reflections on distribution, empowerment and gender justice in Northern Tanzania and Northern Nigeria. **International Journal of Educational Development** 33(6), pp. 566-575.

Vahasantanen, K. and Saarinen, J. (2012) The power dance in the research interview: manifesting power and powerlessness. **Qualitative Research** 13(5), pp. 493-510.

Velligan, D. I., et al. (2003) Psychopharmacology: perspective on medication adherence and atypical antipsychotic medications. **Psychiatric services**, 54, pp.665-667.

Vigoya, M. (2001) Contemporary Latin American perspectives on masculinity. **Men and Masculinities**, 3(3), pp.237-260.

Watson, J. (2000) **Male bodies: Health, Culture and Identity**. Buckingham, Open University Press.

Walker, L. (2005) Men behaving differently: South African men since 1994. **Culture, health and sexuality**, 7(3), pp.25-238.

Walls, P., et al. (2010) Issues and considerations when researching sensitive issues with men: examples from a study of men and sexual health. **Nurse Researcher** 18(1), pp.26-34.

Warner, R. (2010) Does the scientific evidence support the recovery model. **The Psychiatrist**, 34, pp.3-5.

Webb, A. L. (2012) Beliefs in ancestral witchcraft fostering abuse of children. **Christian Century**, 129(7), pp.21-30.

Weintritt, J. (2007) The use of plants in traditional medicine in Nigeria. **Africana Bulletin**, 1, pp.119-131.

Weiss, R. (1994) **Learning from strangers: the art and method of qualitative interview studies**. New York, Free Press.

White, R. (2002) Social and political aspects of men's health. **Health**, 6(3), pp.267-285.

Whitley, R. and Drake, R. (2010) Recovery: a dimensional approach. **Psychiatric Services** 61(12), pp.1247-1250.

Wiesjahn, M., et al. (2014) Explaining attitudes and adherence to antipsychotic medication: the development of a process model. **Schizophrenia Research and Treatment**, 3, pp. 2-21

Williams, R., et al. (2013) Changing fatherhood: an exploratory qualitative study with African and African Caribbean men in England **Children and society**, 27(2), pp.92-103.

Willig, C. (2013) **Introducing qualitative research in psychology**. United Kingdom, McGraw-Hill Education.

Wilson, D. (2003) Forms of male domination and female subordination: homeworkers versus masquiladora workers in Mexico. In: Whitehead, M. S. (Ed.): **Men and masculinities: critical concepts in Sociology**. London, Routledge, pp.215-235

Wood, W. and Eagly, A. (2012) Biosocial construction of sex differences and similarities in behaviour. In: Olson, J. and Zanna, M. (Eds.): **Advances in experimental social psychology**. Burlington, Academic Press, pp.55-123

Woodall, J., et al. (2010). **Empowerment and health & well-being**. Leeds Metropolitan University, Centre for Health Promotion and Research.

Woodberry, R. (2004). **The shadow of empire: Christian missions, colonial policy and democracy in postcolonial societies**. University of North Carolina, Department of Sociology.

World Health Organisation (1996). **World Health Organisation quality of life, introduction, administration, scoring and generic version of the assessment**. Geneva, World Health Organisation.

World Health Organisation (2001). **Mental health: new understanding, new hope**. Geneva, World Health Organisation.

World Health Organisation (2004). **Promoting mental health: concepts, emerging evidence, practice**. Geneva, World Health Organisation.

World Health Organisation (2006). **Report on mental health system in Nigeria**. Ibadan, WHO and Ministry of Health Ibadan Nigeria.

World Health Organisation (2010). **International statistical classification of diseases and related health problems**. Geneva, World Health Organisation.

World Health Organisation (2011). ***Mental Health Gap: mental Health Action Programme: scaling up care for mental, neurological, and substance use disorders***. Geneva, World Health Organisation.

World Health Organisation (2013a). ***African Region Gender Plan 2013-2017***. Geneva, World Health Organisation.

World Health Organisation (2013b). ***Mental Health Action Plan for 2013-2020***. Geneva, World Health Organisation.

World Health Organisation (2013c). ***Traditional Medicine Strategy 2014-2023***. Geneva, World Health Organisation.

World Health Organisation (2015a). ***Schizophrenia***. Geneva, World Health Organisation.

World Health Organisation (2015b). ***Gender***. Geneva, World Health Organisation.

Yeomans, D., et al. (2014) Resolution and remission in schizophrenia: getting well and staying well. ***Advances in Psychiatric Treatment***, 16(2), pp.86-95.

Young, S. L. and Bullock, W. (2003). ***Mental health recovery measure***. Ohio, University of Toledo, Department of Psychology.

Yusuf, A. J., Nuhu, F. T. and Akinbiyi, A. (2009) Caregiver burden among relatives patients with schizophrenia in Katsina Nigeria. ***South African Journal of Psychiatry***, 15(2), pp.43-47.

Yusuf, A. J. and Nuhu, I. T. (2010) Consequences of untreated severe psychiatric disorders in northern Nigeria. ***African Journal of Psychiatry***, 13(2), pp.92-94

Zubin, J. and Spring, B. (1977) Vulnerability: a new view on schizophrenia. ***Journal of Abnormal Psychology***, 86, pp.103-126.

## APPENDIX ONE RESEARCH PROTOCOL

### **Recovery from schizophrenia: experiences of men in northern Nigeria**

#### **Study Rationale**

A recent study carried out in Nigeria by Afolayan, Peter and Amasueba, (2010) suggests that males have a higher incidence of schizophrenia when compared to females.

Olawoye et al. (2004) in a study which explored the social construction of masculinity argues that in traditional Nigerian societies, the man's role in the family is different to that of the woman. In particular men have a responsibility to provide financially for the upkeep of the family (Morrell and Ouzgane, 2005). It appears adherence to social norms and traditional views about gender might have implications for men's experiences of recovery from mental illness. Odimegwu and Okemgbo (2008) also point to detrimental effect of traditional masculine expectations learnt through the socialization process in Nigeria, where it was suggested that beliefs about masculinity give rise to certain behaviours. For example, men are taught to be strong and may refuse to seek help in an effort to avoid being perceived as weak. As a result, it seems that the socio-cultural context of men growing up in Nigeria and their gendered expectations might have impact on their recovery from schizophrenia.

#### **Study Aim**

This study aims to explore the factors that influence men's recovery from schizophrenia in northern Nigeria.

#### **Research Questions**

This qualitative study will address the following questions:

- i. What are perceptions and experiences of developing schizophrenia in Nigeria?
- ii. What factors influence men's recovery from schizophrenia?

#### **Inclusion Criteria**

Around thirty men aged 18 to 65 years previously diagnosed with schizophrenia, who are currently in contact with the hospital, and living in the community, will be purposively sampled to ensure age spread. Similarly, hospital staff with experience of supporting these male service users will be included.

## **Exclusion Criteria**

Individuals will be excluded from the study if they fall into one or more of the following groups:

- i. Those who are under the age of 18 years
- ii. Those who have a learning disability
- iii. Those who are currently acutely affected by psychotic symptoms as assessed by the Consultant Psychiatrist.

## **Recruitment of participants**

Out-patients who attend at the hospital will be approached by the Consultant Psychiatrist for initial invitation to take part in the study. They will be given an Initial Invitation inviting them to take part, along with the Participant Information Sheet explaining the study. Participants who agree to take part are asked to return the reply slip to the researcher in the pre-paid envelope provided. The researcher will then make contact to discuss the study, answer any questions and arrange a suitable time for an interview.

## **Data Collection**

Individual face-to-face interview using a semi-structure guide will take place in a hospital. The session will take up to an hour and digital audio recorder used.

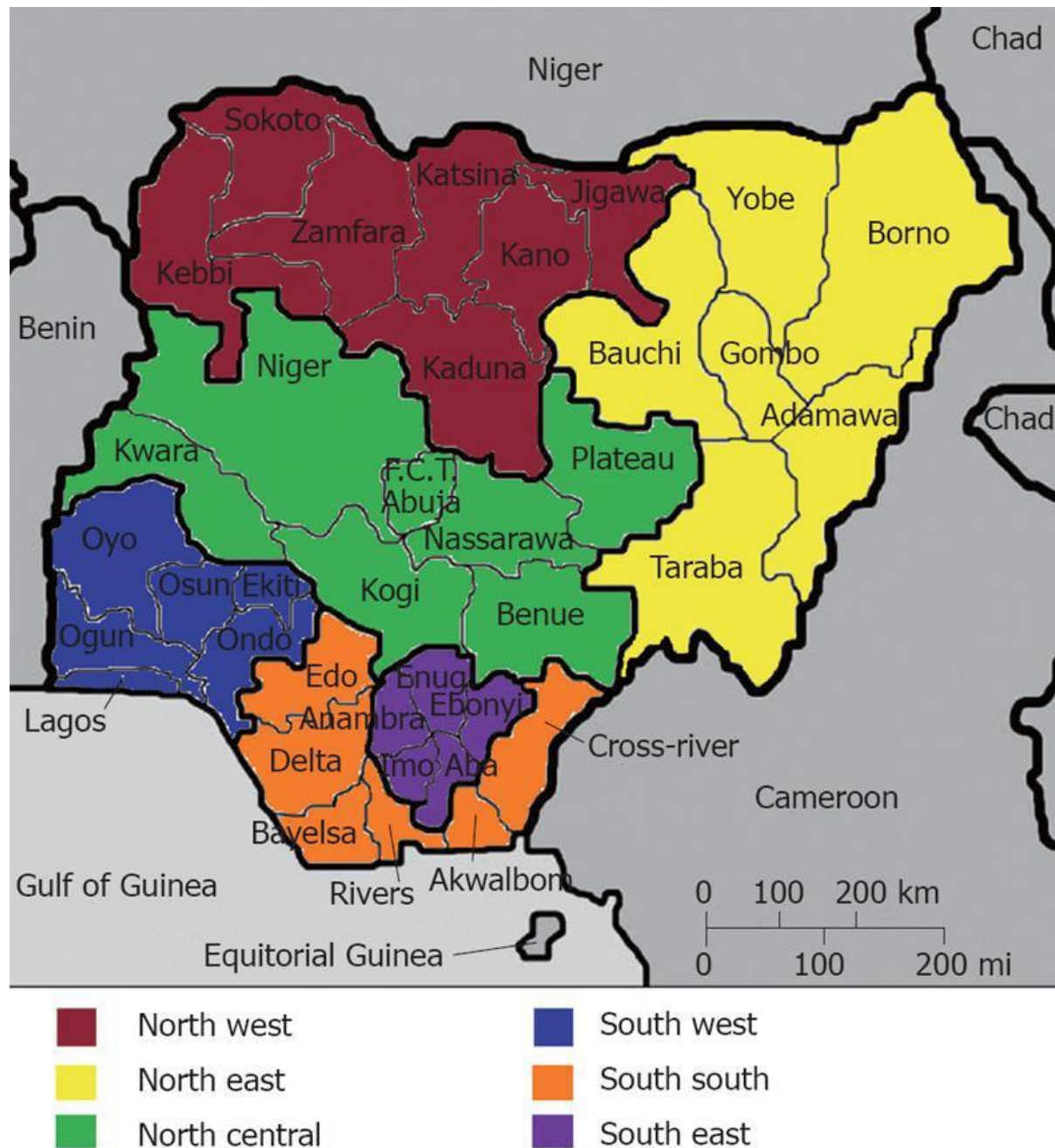
## **Data Analysis**

Thematic analysis will be used to analyse data. This involves identifying themes defined as coherent patterns across data (Braun and Clarke, 2006). Examining data to develop meanings will also highlight the particular experiences which majority of participants have in common.

Using this approach to data analysis as Boyatzis (1998); Braun and Clarke (2006) suggests, can be useful in highlighting key features of data. It can also lead to unanticipated insights that help address research questions, through highlighting similarities and differences across data. Finally, results are accessible to inform the public about the study.

## APPENDIX TWO A MAP OF NIGERIA

Part of Appendix two has been redacted for copyright purposes. You can access the original population information here <http://population.gov.ng/>





## APPENDIX THREE: INVITATION LETTER TO STUDY PARTICIPANTS

Dear Mr...

### **Recovery from schizophrenia: experiences of men in northern Nigeria**

I am writing to invite you to take part in a study about men's experiences of recovery from schizophrenia to help understand ways to support men who like you had been diagnosed with schizophrenia. The researcher Bello Utoblo (Telephone: 0706 815 2527. Email: b.utoblo@leedsmet.ac.uk) is a student at Leeds Metropolitan University, England. As part of this course of study he is required to complete a research.

Taking part is voluntary. If you do not want to take part you do not have to, nor do you have to give a reason for not doing so. There will be no effect on your care if you decide not to take part. To help you decide, I have enclosed a Participant Information sheet explaining the project.

If you would like to take part, please complete the enclosed reply slip and return to the researcher in the pre-paid envelope provided.

Yours Sincerely,

.....

Psychiatrist



## APPENDIX FOUR: PARTICIPANT INFORMATION SHEET



**leeds metropolitan university**

**Faculty of Health & Social Sciences**

**City Campus**

**Telephone: 0113 812 0000**

**Leeds LS1 3HE**

**Web: [www.leedsmet.ac.uk](http://www.leedsmet.ac.uk)**

**England**

### **Participant Information Sheet**

**Recovery from Schizophrenia: experiences of men in northern Nigeria.**

**Leeds Metropolitan University, Faculty of Health & Social Sciences Research.**

Thank you for taking an interest in this research. To help you decide if you want to take part or not, the researcher wants to tell you why the research is being done, and what you can expect if you do take part. Please read this information sheet carefully. Talk about it with friends, relatives and your doctor if you wish.

### **What is the purpose of the study?**

This is an educational study. It is carried out as part of the researcher's studies with Leeds Metropolitan University, Faculty of Health & Social Sciences, and England.

### **Why have I been chosen?**

The study aims to explore men's experiences of recovery from schizophrenia in Nigeria. Around thirty men aged 18 to 65 years previously diagnosed with schizophrenia, currently in contact with the hospital, and living in the community, will be invited to take part. Individuals under the age of 18 years, or those with a learning disability, or currently acutely affected by psychotic symptoms or those deemed vulnerable will be excluded. Your experience of recovery is vital as service users like you can help provide information helpful to understand more the support for people like you.

### **Do I have to take part?**

No. Participation is voluntary. It is entirely up to you to decide whether or not you want to take part. If you decide to take part, you will be asked to sign a consent form. Deciding whether or not to take part will not affect the standard of care you receive.

### **What will happen if I take part?**

You will be invited to attend an individual interview with the researcher at the hospital. The interview will last up to an hour, during which time you will be asked some questions about your experiences of schizophrenia and of your recovery. The interview will be audio recorded and a second interview could be necessary, but a suitable time for this will be agreed with you. The hospital has given permission to carry out the research and interviews on their premises, but the researcher is independent from the hospital.

### **What are the benefits of taking part?**

This study will offer you a chance to have your say about your experiences of recovery. Through learning more about men's experiences of recovery, new information can be obtained helpful to improve services for people. Participants travel expenses will be refunded.

### **What are the disadvantages of taking part?**

There is the possibility that remembering your experiences may become upsetting for you during the interviews. If such situations arise, help will be available from your Consultant Psychiatrist if you wish.

### **Will taking part be kept confidential?**

Yes. The information that you provide will be kept confidential. Your medical records will not be accessed by the researcher. However, should information presented indicate a significant threat to your safety or that of others, the researcher will have to contact appropriate authorities. Data will be stored on computer where access is password protected. Audio tapes will be wiped after transcription. Filing cabinets on secure premises will be used to separately store data where access is by the researcher. There will be no hospital access to your data. All identifiable information will be destroyed after study completion.

### **What if there is a problem?**

If you have a concern, please contact the Researcher or Director of Studies. If you wish to raise your concern with someone independent you can contact Ms Sheila Casey, Faculty Research Ethics Committee administrator, Faculty of Health & Social Sciences, Room G28 Queen Square House, Leeds Metropolitan University, City Campus, Leeds LS1 3HE England (Telephone 0113 812 4312 or Email [s.a.casey@leedsmet.ac.uk](mailto:s.a.casey@leedsmet.ac.uk)).

### **What if I decide to withdraw after the interview has taken place?**

You are free to leave the study. If you decide to leave after the interview, you have up until three weeks to withdraw data, because it would be impossible to remove your data once the findings are published. You can notify the researcher of your decision to withdraw from the study.

### **Who has reviewed the study?**

Research ethical approval has been obtained from the Faculty of Health & Social Sciences Research Ethics Committee, Leeds Metropolitan University, England and the Research Ethics Committee, Federal Neuro-Psychiatric Hospital, Nigeria.

### **How will the findings be made available?**

Publication of a thesis, journals and conference presentations, but you will not be named or identified as quotations used will be anonymous. A lay summary of the thesis will be posted to participants.

### **What should I do next?**

If you complete and send back the enclosed reply slip in the pre-paid envelope provided, the researcher will contact you to answer any questions that you might have and to arrange a suitable time for interview.

### **Contact for further information**

The researcher hopes that this information sheet has told you what you need to know before deciding whether or not to take part. Should you need further information, please contact the researcher, Bello Utoblo email: [b.utoblo@leedsmet.ac.uk](mailto:b.utoblo@leedsmet.ac.uk) tel: 0706 815 2527 or Director of Studies, Professor Alan White email [a.white@leedsmet.ac.uk](mailto:a.white@leedsmet.ac.uk) tel: 009 44 113 812 4358

**Thank you for reading this information sheet about the study.**

## APPENDIX FIVE: PARTICIPANT REPLY SLIP

**Recovery from schizophrenia: experiences of men in northern Nigeria.**

**Leeds Metropolitan University, Faculty of Health and Social Sciences Research.**

Yes, I would be interested in participating in this research.

Name: .....

Address:.....  
.....  
.....

Telephone number:

Best time to be contacted:

Age:

Marital status:

Occupation:

Religion:

Signed:

Date:

**Please return to:**

Bello Utoblo

c/o Federal Neuro-Psychiatric Hospital

Telephone: 0706 815 2527

Email: b.utoblo@leedsmet.ac.uk

(pre-paid envelope provided)

## APPENDIX SIX: THE CONSENT FORM



leeds metropolitan university

Faculty of Health & Social Sciences

City Campus

Tel: 0113 812 0000

Leeds LS1 3HE

Web: [www.leedsmet.ac.uk](http://www.leedsmet.ac.uk)

**Recovery from schizophrenia: experiences of men in northern Nigeria.**

**Leeds Metropolitan University, Faculty of Health & Social Sciences Research.**

Please  
initial

- I agree to take part in the above study.
- All my questions about this study have been satisfactorily answered.
- I understand that my participation is voluntary, that I have up until three weeks after interview to withdraw data from the study.
- I understand that my medical records will not be accessed by the researcher.
- I agree to my interview being audio recorded.
- I understand the results will be published, and this includes thesis, journals and conference presentations.
- I give permission for the use of direct quotes and understand that I will not be named or identified in any reports based on this research as quotations will be anonymous.
- I understand that whilst the information provided will be confidential, should information presented indicate a significant threat to my safety or the safety of others, the researcher will have to contact the appropriate authorities.

☐☐☐☐☐☐☐☐

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## APPENDIX SEVEN: INTERVIEW GUIDE



leeds metropolitan university

Faculty of Health & Social Sciences

City Campus

Telephone: 0113 812 0000

Leeds LS1 3HE

**Recovery from schizophrenia: experiences of men in northern Nigeria.**

**Leeds Metropolitan University, Faculty of Health & Social Sciences Research.**

### **Introduction**

-Thank you

-Researcher's name

-Purpose of interview

- Interview duration

-How interview will be conducted

-Confidentiality

-Signature of consent

I want to thank you for taking the time to meet with me today. My name is Bello Utoblo and I would like to talk to you about your experiences of recovery from mental health problem. As part of my studies with Leeds Metropolitan University, Faculty of Health & Social Sciences, England, I am exploring men's experiences of recovery from schizophrenia and interested to find out whether there are any things that have helped or hindered your recovery so far.

The interview should take around an hour. It will be audio taped, because I do not want to miss any of your comments. Remember, that there are no right or wrong answers and to ask for clarifications if you do not understand what a specific question is getting at. You do not have to talk about anything that you do not want to and you may end the interview at any time. All responses will be kept confidential. This means that any information included in the student report will not identify you. However, should information presented indicate a significant threat to your safety or safety of others then I will have to contact appropriate authorities.

### **1. Participants characteristics.**

a. Could you tell me a little about yourself? Encourage participant to talk in order to elicit information about their background...

Prompts:

-What is your occupation?

### **2. Possible causes of schizophrenia**

a. You have been asked to take part in this interview because you have some experience of supporting service users. What do you believe are the causes of schizophrenia?

Prompts:

-What are some of the reasons you believe can lead to mental illness?

-What do you think mental illness can be due to?

b. What do you think are some of the symptoms of schizophrenia?

Prompts:

-Can you tell me how schizophrenia can affect someone?

### **3. Meaning of recovery**

a. Recovery is a term that is used within services to refer to your getting better. What does recovery mean to you?

Prompts:

-How would you describe recovery?

b. How else would you describe the experiences of getting better or healing? Prompt:

- What other term would you find helpful in describing your experiences of getting better or healing?



#### **4. Impact of gender and other socio-cultural aspects on men's recovery**

a. As discussed, this study is exploring the relationship between gender roles and men's recovery from mental illness. What do you believe are the man's role in traditional Nigerian family? These may include beliefs about what constitute masculine behaviour, beliefs about the man's role in traditional Nigerian family...

Prompt:

-In what ways can you fulfil your role of being a man?

b. In what ways do you think that gender roles can impact on men's recovery? Encourage participant to talk about how gender role might impact on men's recovery.

Prompt:

-What are the good and bad aspects of man's role in the family?

c. What do you think are the factors which have facilitated changes in the traditional role of men in Nigeria? Encourage participant to talk about the various factors which have facilitated transformations in gender roles in contemporary Nigeria.

Prompt:

-In what ways do you believe women role are changing in current times?

#### **5. Things that have helped men's recovery so far**

a. Could you tell me what things you believe could help in men's recovery? Encourage participant to talk about the various aspects of what they think can be important in men's recovery. These may include a person, religion, medication, and man's role in the family...

Prompt:

-What do you think are the most important things that can help men's recovery?

## **6. Things that might have hindered men's recovery so far**

a. Could you tell me about what things you believe can hinder men's recovery?

Prompt:

-Are there things you believe can make managing men's recovery difficult?

-Is there anything that could have done differently?

Closing the interview

-Final reflections

-Opportunity for participant to ask questions

-Contact for further support

-Thank you

At the start of the interview, I mentioned that I am interested in exploring your experiences of supporting service users. We are coming to the end of the interview. Is there additional information that you want to add?

Thank you for your time and sharing information with me. Should you need to talk with someone about the interview please do not hesitate to contact me. Give them the information sheet with the contact numbers of the researcher.

## APPENDIX EIGHT: UNIVERSITY ETHICAL APPROVAL 2012



leeds metropolitan university

Faculty of Health  
& Social Sciences

City Campus  
Leeds LS1 3HE

Tel: 0113 812 0000  
Web: [www.leedsmet.ac.uk](http://www.leedsmet.ac.uk)

Bello Utoblo  
PhD researcher  
Centre for Men's Health  
Faculty of Health & Social Sciences  
Queen Square House

[b.utoblo@leedsmet.ac.uk](mailto:b.utoblo@leedsmet.ac.uk)

7 February 2012

Dear Bello

**Research ethics application: 260. Recovery from schizophrenia: experiences of men in Northern Nigeria (resubmission)**

The Faculty of Health & Social Sciences Research Ethics Committee reviewed the above application at the meeting held on 7 February 2012. Thank you for attending the meeting to discuss your application, with your Director of Studies, Professor Alan White.

### Documents reviewed

The documents reviewed at the meeting were:

1.	Faculty undertaking and approval form
2.	Application form
3.	Response to the Committee's comments on application 248
4.	Research protocol
5.	Invitation letter from the Federal Neuro-Psychiatric Hospital, Kaduna
6.	Initial invitation to potential participants
7.	Reply slip
8.	Participant information sheet
9.	Consent form
10.	Interview schedule
11.	Correspondence regarding the Research Ethical Committee, Federal Neuro-Psychiatric Hospital
12.	Confirmation from the Federal Neuro-Psychiatric Hospital regarding permission to carry out your research there
13.	Risk form and insurance schedule of cover

### Confirmation of ethical approval

On behalf of the Committee, I am pleased to confirm a favourable opinion for the above research on the basis described in the application form and supporting documentation.

The members made some comments and recommendations (below) for your consideration.

Please notify the Faculty Research Ethics Committee if there are any significant changes in the study. For your information, ethical approval is granted for a period of two years, after which point you will need to apply for an extension of approval (please note however that a full re-application will not be necessary unless the protocol has changed). Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

On behalf of the Committee I would like to express our good wishes and hope that there will be a successful outcome to your research.

Yours sincerely



Dr John Willott  
Chair of the Faculty Research Ethics Committee  
Faculty of Health & Social Sciences  
email j.willott@leedsmet.ac.uk

Cc Director of Studies, Alan White

Sheila Casey, Research ethics administrator  
Faculty of Health & Social Sciences, Room G28 Queen Square House  
Leeds Metropolitan University, City Campus, Leeds, LS1 3HE  
tel 0113 812 4312, s.a.casey@leedsmet.ac.uk

#### **COMMENTS AND RECOMMENDATIONS**

1. When you receive approval from the Research Ethical Committee, Federal Neuro-Psychiatric Hospital, a copy should be sent to the research ethics administrator for lodging with your application.
2. Within the Participant Information Sheet:
  - In the section 'What is the purpose of the study', the purpose and aims of the study should be included in wording understandable to the average person
  - It could be clearer that participants can withdraw during the interview from the project, if they wish.
3. In the letter of invitation, the first paragraph, final sentence, needs the word project adding at the end.
4. As discussed at the meeting, you and your supervisory team will regularly review the risk assessment for the project in view of any local changes during your visit in April to Nigeria.

## APPENDIX NINE: ETHICAL APPROVAL STAFF INCLUSION 2013



Faculty of Health & Social Sciences  
Leeds Metropolitan University  
City Campus  
Leeds  
LS1 3HE

[www.leedsmet.ac.uk](http://www.leedsmet.ac.uk)

Bello Utoblo  
PhD researcher  
Centre for Men's Health  
Faculty of Health & Social Sciences  
Queen Square House

[b.utoblo@leedsmet.ac.uk](mailto:b.utoblo@leedsmet.ac.uk)

3 May 2013

Dear Bello

**Research ethics application: 260. Recovery from schizophrenia: experiences of men in Northern Nigeria (approved February 2012) – amendment to the project**

Thank you for submitting the details of the amendment to the above approved study with the addition of staff at the hospital as participants in the project.

### Documents reviewed

1.	Invitation to staff and reply slip
2.	Participant information sheet
3.	Consent form
4.	Interview schedule
5.	Revised research proposal

### Confirmation of ethical approval

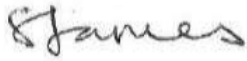
On behalf of the Committee, I am pleased to confirm a favourable opinion for the additional data collection for your study on the basis described in the documentation.

Please ensure you receive agreement from the Federal Neuro-Psychiatric Hospital for accessing the potential staff participants and if required, any local ethical approval for this change, prior to commencement of this part of the project.

Please notify the Faculty Research Ethics Committee if there are any significant changes in the study. For your information, ethical approval is granted originally for a period of two years, after which point you will need to apply for an extension of approval (please note however that a full re-application will not be necessary unless the protocol has changed). Please would you also note that we may, for the purposes of audit, contact you from time to time to ascertain the status of your research.

On behalf of the Committee I would like to express our good wishes and hope that there will be a successful outcome to your research.

Yours sincerely



Dr Sarah James  
Chair of the Faculty Research Ethics Committee  
Faculty of Health & Social Sciences  
email [s.james@leedsmet.ac.uk](mailto:s.james@leedsmet.ac.uk)

In case of queries, please contact in the first instance:  
Sheila Casey, Quality Assurance and Governance Officer/Research Ethics Administrator  
Faculty of Health & Social Sciences, Room G28 Queen Square House  
Leeds Metropolitan University, City Campus, Leeds, LS1 3HE  
tel 0113 812 4312, [s.a.casey@leedsmet.ac.uk](mailto:s.a.casey@leedsmet.ac.uk)



## APPENDIX TEN: HOSPITAL ETHICAL APPROVAL 2012

<b>FEDERAL NEURO-PSYCHIATRIC HOSPITAL, KADUNA</b> <b>BARNAWA, KADUNA NIGERIA.</b>	
<div style="text-align: center;"></div> <div style="text-align: right;"><b>OFFICE:</b> Opposite Shagari Low Cost P.M.B. 2187, Barnawa Kaduna ☎: 062-230001-3, 237308-10. E-mail: fnphkaduna@yahoo.com</div>	
Date: 29/08/2012	
<b>Medical Director</b> DR. T. L. SHEIKH MBBS (ABU) M.Sc., FWACP	<b>HEALTH RESEARCH ETHICS COMMITTEE</b>  <b>Notice of Full Approval</b> Re: Recovery from schizophrenia: experiences of men in Northern Nigeria Name of Principal Investigator: <b>Bello Utoblo</b> Address of Principal Investigator: <b>Leeds Metropolitan University, Faculty of Health &amp; Social Sciences Research, Queen Square House, 80 Wood House Lane, Leeds, LS28NU</b> Date of receipt of valid application: <b>20<sup>th</sup> February 2012</b> Date of meeting when final determination of research was made: <b>27<sup>th</sup> August 2012</b>  This is to inform you that the research described in the submitted protocol, the consent procedure, and other participant information materials have been reviewed and <i>given full approval by the Health Research Ethics Committee.</i> This approval dates from 27 <sup>th</sup> August 2012 to 31 <sup>st</sup> March 2013. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates.  The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC. The HREC reserves the right to conduct compliance visit your research site without previous notification.
<b>Head of Clinical Services</b> DR. EBITI W.N. MBBCH (CAL) FWACP	
<b>Asst Director of Administration/ Secretary to Board</b> ALHAJI MAHMUD ALHASSAN B.Sc. MPA, CHPM, AHAN, MNIM, NIPR	
	<div style="text-align: center;"> Dr. Ebiti William N. Chairman, HREC</div> <div style="text-align: center;"> Dr. Folorunsho T. Nuhu Secretary, HREC</div> <div style="text-align: center;"><div style="border: 1px solid black; padding: 5px; display: inline-block;"><b>* Director of Clinical Services</b> <b>FEDERAL NEURO-PSYCHIATRIC HOSPITAL</b> Barnawa - Kaduna.</div></div>
<div style="text-align: center;"><b>THE BOARD OF MANAGEMENT</b> <b>Chairman: ALHAJI RAMALAN A. YERO (Turakin Dawakin Zazzau)</b> <b>Members: Hajia Hauwa Musa Kida, Dr. Seyi Roberts, Alh. Muktar Maimaje Mrs. Zainab Tatari Mahmood, Dr. Yagana Imam Musa DR. T. L. SHEIKH, DR. EBITI W.N.</b></div>	

## APPENDIX ELEVEN HOSPITAL ETHICAL APPROVAL 2013

### FEDERAL NEURO-PSYCHIATRIC HOSPITAL, KADUNA

BARNAWA, KADUNA NIGERIA.



OFFICE:  
Opposite Shagari Low Cost  
P.M.B. 2187,  
Barnawa Kaduna  
☎ : 062-230001-3, 237308-10.  
E-mail: fnphkaduna@yahoo.com

27<sup>th</sup> March 2013

Medical Director

DR. T. L. SHEIKH

MBBS (ABU) M.Sc., FWACP,

Head of Clinical Services

DR. EBITI W.N.

MBBCH (CAL) FWACP

Asst Director of Administration/  
Secretary to Board

ALHAJI MAHMUD ALHASSAN

B.Sc. MPA, CHPM, AHAN, MNIM, NIPR

#### HEALTH RESEARCH ETHICS COMMITTEE

##### Notice of Full Approval

Re: **Recovery from Schizophrenia: Experience of Men in Northern Nigeria**

Name of Principal Investigator: **Bello Utoblo**

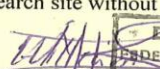
Address of Principal Investigator: **Leeds Metropolitan University, Faculty of Health & Social Sciences Research, Queens Square House, 80 Wood House Lane, Leeds, LS28NU**

Date of receipt of valid application: **15th March 2013**

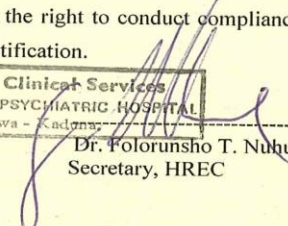
Date of meeting when final determination of research was made: **27th March 2013**

This is to inform you that the research described in the submitted protocol, the consent procedure, and other participant information materials have been reviewed and *given full approval by the Health Research Ethics Committee* to extend the study period. This approval dates from 1<sup>st</sup> April 2013 to 31<sup>st</sup> September 2013. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC. The HREC reserves the right to conduct compliance visit your research site without previous notification.

  
Director of Clinical Services  
FEDERAL NEURO-PSYCHIATRIC HOSPITAL  
Barnawa - Kaduna

Dr. Ebiti William N.  
Chairman, HREC

  
Dr. Folorunsho T. Nuhu  
Secretary, HREC

#### THE BOARD OF MANAGEMENT

Chairman: ALHAJI RAMALAN A. YERO (Turakin Dawakin Zazzau)

Members: Hajia Hauwa Musa Kida, Dr. Seyi Roberts, Alh. Muktar Maimaje Mrs. Zainab Tatari Mahmood, Dr. Yagana Imam Musa  
DR. T. L. SHEIKH, DR. EBITI W.N.